

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15702

## CERTIFICATE OF DEATH

15704

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> (Rural) <u>07-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wayne</u> Last <u>ABRAMS</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-26-66</u>
9. AGE (In years last birthday) yrs. <u>7</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>11</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>HARFORD, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ronald Lee Abrams</u>		14. MOTHER'S MAIDEN NAME <u>Betty Joanne McMillan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Alonso Gomez, M.D.</u>		Address <u>4195 Union Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute fulminant hepatitis</u> DUE TO <u>570X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cause undetermined.</u> DUE TO (c) <u>                    </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>                    </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>                    </u> , 19 <u>          </u> , to <u>                    </u> , 19 <u>          </u> , that (I) (we) last saw the deceased alive on <u>Nov. 3</u> 19 <u>66</u> and that death occurred at <u>2A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alonso Gomez</u>		22b. DATE SIGNED <u>11/3/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alonso Gomez, M.D.</u>		22d. ADDRESS <u>4195 Union Ave, Harre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov 5/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bay View Meth. Cem</u>	23d. LOCATION (City or Town) (County) (State) <u>Bay View, Cecil, Md.</u>
24. FUNERAL DIRECTOR <u>Hicks Home for Funerals, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 18 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
 HEALTH DEPT.

15703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15705

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>D.O.A.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b>		d. STREET ADDRESS <b>Calvary Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raby</b> Middle <b>James</b> Last <b>Bratton</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 20, 1913</b>
9. AGE (In years last birthday) yrs. <b>53</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
11. BIRTHPLACE (State or foreign country) <b>Fries, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Bratton</b>		14. MOTHER'S MAIDEN NAME <b>Louivillia V. Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>229-18-0132</b>	
17. INFORMANT (Name) <b>Mrs. Elsie S. Bratton</b>		Address <b>RFD #2, Box #112A Bel Air, Md. 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off tractor &amp; it ran over his head</b>	
20c. TIME OF INJURY Month, Day, Year <b>3:15 p.m. 11-4 1966</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm Claude Smith</b>	20f. (City or town) (County) (State) <b>Bel Air Harf. Co. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Bel Air, Md. 21014</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Meth. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Fountain Green, Harf. Co., Md.</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pooled with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15704

**CERTIFICATE OF DEATH**

15706

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Route 2 Box 352</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Lincoln Brumbaugh</u>				4. DATE OF DEATH Month Day Year <u>Nov 8 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>31 Dec. 1895</u>		9. AGE (In years lost birthday) yrs. <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supply Clerk (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. APG</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David D. Brumbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Katura Ickes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-1</u>		16. SOCIAL SECURITY NO. <u>213-12-0733</u>		17. INFORMANT Address <u>Viola C. Brumbaugh, Street, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 8, 1966</u> , to <u>Nov 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov. 8, 1966</u> , and that death occurred at <u>4:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>11-8-66</u>		22c. PHYSICIAN'S NAME (Type) <u>A. L. LEWIS MD</u>	
22d. ADDRESS <u>Havre de Grace, Maryland</u>				22e. REC'D BY REGISTRAR <u>[Signature]</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11 Nov. 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Slate Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Delta York Penna.</u>	
24. FUNERAL DIRECTOR <u>Walter Macomber Sr.</u>				24b. ADDRESS <u>Aberdeen, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15705

CERTIFICATE OF DEATH

15707

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace, Md</u>		d. STREET ADDRESS <u>106 Wilson St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>66 Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Pearl</u> Last <u>Carson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Severed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Abraham Bros. Ltd</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Craig</u>		14. MOTHER'S MAIDEN NAME <u>Leah Patterson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>320-22-0789</u>	
17. INFORMANT <u>Martin Carson, Havre de Grace, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerotic Heart disease</u> DUE TO (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>66</u> , to <u>11-29</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11-29</u> 19 <u>66</u> , and that death occurred at <u>6:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Irvin L. Wachsmann</u> M.D.		22b. DATE SIGNED <u>11/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>IRVIN L. WACHSMANN M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 2, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Eastport Cecil Md</u>	
24. FUNERAL DIRECTOR <u>Lee G. Patterson &amp; Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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RECEIVED BY AIRMAIL  
JAN 10 1964  
U.S. AIR FORCE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15706

CERTIFICATE OF DEATH

15708

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b> c. LENGTH OF STAY IN 1b <b>5 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIRK ARMY Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hanford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Edgewood, Maryland</b> d. STREET ADDRESS <b>1625 Silver Bell Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MANLY J. CUMMINGS</b>		4. DATE OF DEATH <b>11 8 1966</b>	
5. SEX <b>male</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 7, 1915</b> 9. AGE (in years last birthday) <b>50</b> yrs. 10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Warrant Officer</b> 11b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Muskegon, Michigan</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph MANLY Cummings</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH EBERLY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>029-10-8607</b>		17. INFORMANT <b>Leona Cummings (wife)</b> Address <b>1625 Silver Bell Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Congestive Heart Failure</b> DUE TO (b) <b>Acute Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>36 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		20d. INJURY OCCURRED <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7 November 1966</b> to <b>8 November 1966</b> , that (I) (we) last saw the deceased alive on <b>8 November 1966</b> , and that death occurred at <b>2:45 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Arnold N. Katzoff</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8 November 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARNOLD N. KATZOFF</b>		22d. ADDRESS <b>KIRK ARMY Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>11/13/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Herbert W. ...</b>		25a. REC'D BY REGISTRAR <b>NOV 15 1966</b> 25b. REGISTRAR'S SIGNATURE <b>John H. Judge</b>	

12702

12702



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15707

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15709

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Hartford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d STREET ADDRESS <u>551 Bourbon St</u>	
3 NAME OF DECEASED (Type or print) <u>Horriett Cecelia Dalton</u>		4 DATE OF DEATH <u>November 22, 1966</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-4-1908</u>
9 AGE (In years last birthday) <u>58</u> yrs		10 UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>GALEN Crothers</u>		14 MOTHER'S M maiden name <u>ANNIE TREMBLE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if known) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>220-22-7918</u>	
17 INFORMANT <u>Leslie Crochran</u>		Address <u>Conowingo Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>443A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive + Arteriosclerotic</u> DUE TO (c) <u>cardiovascular cerebral Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be'Au</u> 22. DATE SIGNED <u>11-23-66</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11-26-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>	23d LOCATION (City or town) (County) (State) <u>Peach Bottom PA.</u>
23e FUNERAL DIRECTOR <u>Commonwealth Funeral Home</u>		23f REC'D BY REGISTRAR <u>NOV 28 1966</u>	
23g REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10



TO **DUTY MEDICAL EXAMINER**: This certificate shall be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO **FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, on any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

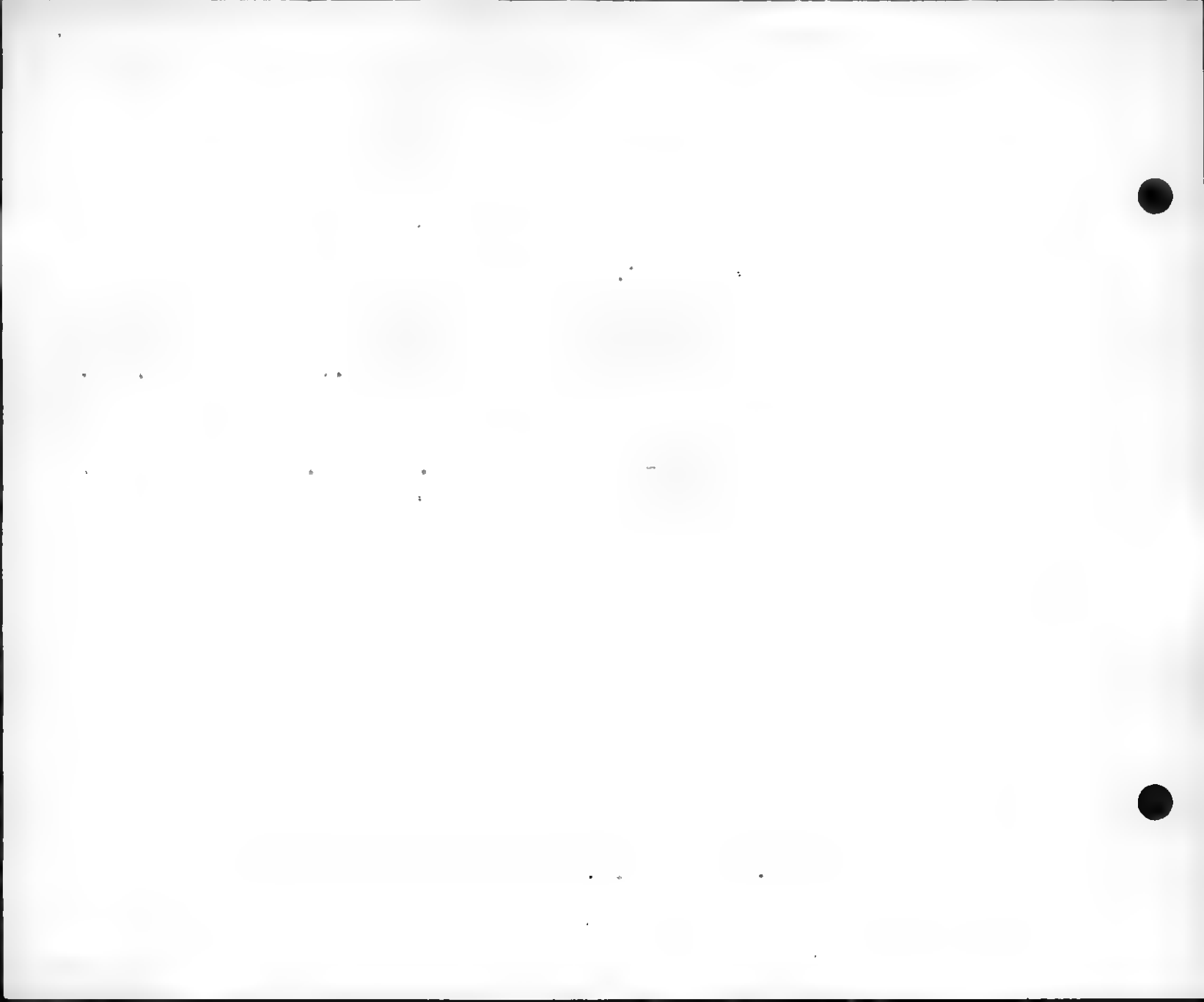
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15708

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15710

1 PLACE OF DEATH a COUNTY <b>Harford</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Harford</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c LENGTH OF STAY IN 1b <b>4 days</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		e STREET ADDRESS <b>403 Ford Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>M.</b> Last <b>Day</b>		4. DATE OF DEATH Month <b>5</b> Day <b>Nov</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Jan 1887</b>
9. AGE (In years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ticket Seller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Theater</b>	
11 BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alex Cullum</b>		14 MOTHER'S MAIDEN NAME <b>Susan Whitcomb</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>215-32-0645</b>	
17 INFORMANT <b>John H. Day Jr.</b>		Address <b>Havre de Grace, Md</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>fracture L. femur</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Nov 1 1966</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <b>Home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Aberdeen Hd Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.		22. DATE SIGNED <b>11-7-66</b>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>BEAIR, Md</b> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-8-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bakers Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Maryland</b>
24. FUNERAL DIRECTOR <b>Samuel B. Dancy</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>	
Tarring Funeral Home <b>Aberdeen, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

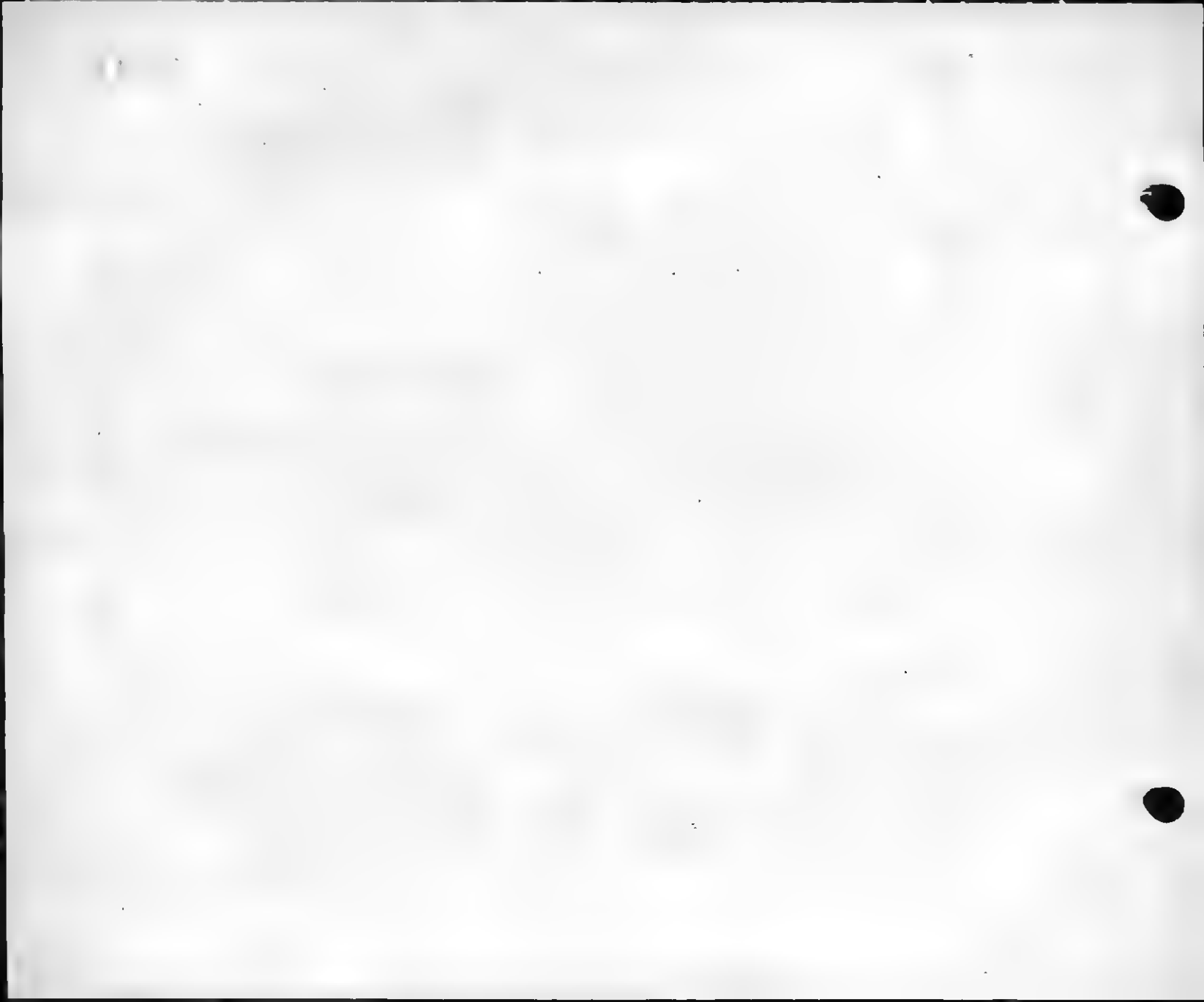
15709

15711

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	
c. LENGTH OF STAY IN 1b <u>2-11-1966</u>		d. STREET ADDRESS <u>801 D. Union Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>610 N. Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Henry</u> First <u>Indians</u> Middle <u>Dyer</u> Last <u>II</u>		4. DATE OF DEATH Month <u>November</u> Day <u>21</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/26/1949</u> 17 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Springfield Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry E. Dyer Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Ruth B. Gallion</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Harry E. Dyer Jr.</u>		Address <u>801 S. Union Ave., Harford County Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to CO</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Poisoned exhaust fumes into car</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11-31</u> 19 <u>66</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Harford</u>	20f. (City or town) (County) (State) <u>Port Deposit</u> <u>Harford</u> <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Donald E. Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bar A</u> 22. DATE SIGNED M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-21-66</u>	
EXAMINER'S NAME (Type) <u>Donald E. Palmer</u>		Address (Street, city, town, or county) <u>Harford</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial</u>	23d. LOCATION (City, town or county) (State) <u>Aldino Md.</u>
24. FUNERAL DIRECTOR <u>Harford</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 23 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
15710		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				15712			
1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			c. LENGTH OF STAY IN ID <b>2 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>South Main Street</b>					d. STREET ADDRESS <b>210 Marshall Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>William Bartlett Evans</b>					4 DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>1966</b>				
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>July 5, 1921</b>		9 AGE (In years, month, birthday, yrs) <b>45</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>District Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bottled Gas</b>		11. BIRTHPLACE (State or foreign country) <b>Davis Co., Kentucky</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Keller Evans</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Ellis Hines</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW #2</b>		16. SOCIAL SECURITY NO <b>406-12-8522</b>		17. INFORMANT (Wife) <b>838-6956</b>			Address <b>P.O. Box #21</b>		
					<b>Mrs. Eugene L. Evans</b>			<b>Bel Air, Md. 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Gerald C. Palmer</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>8. Main Street, Bel Air, Md. 21014</b> DATE SIGNED <b>Nov. 23, 1966</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Owensboro, Davis Co., Ky.</b>			
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		W. Broadway & Williams St. <b>Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>NOV 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Joseph William Foster

25

27

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15711

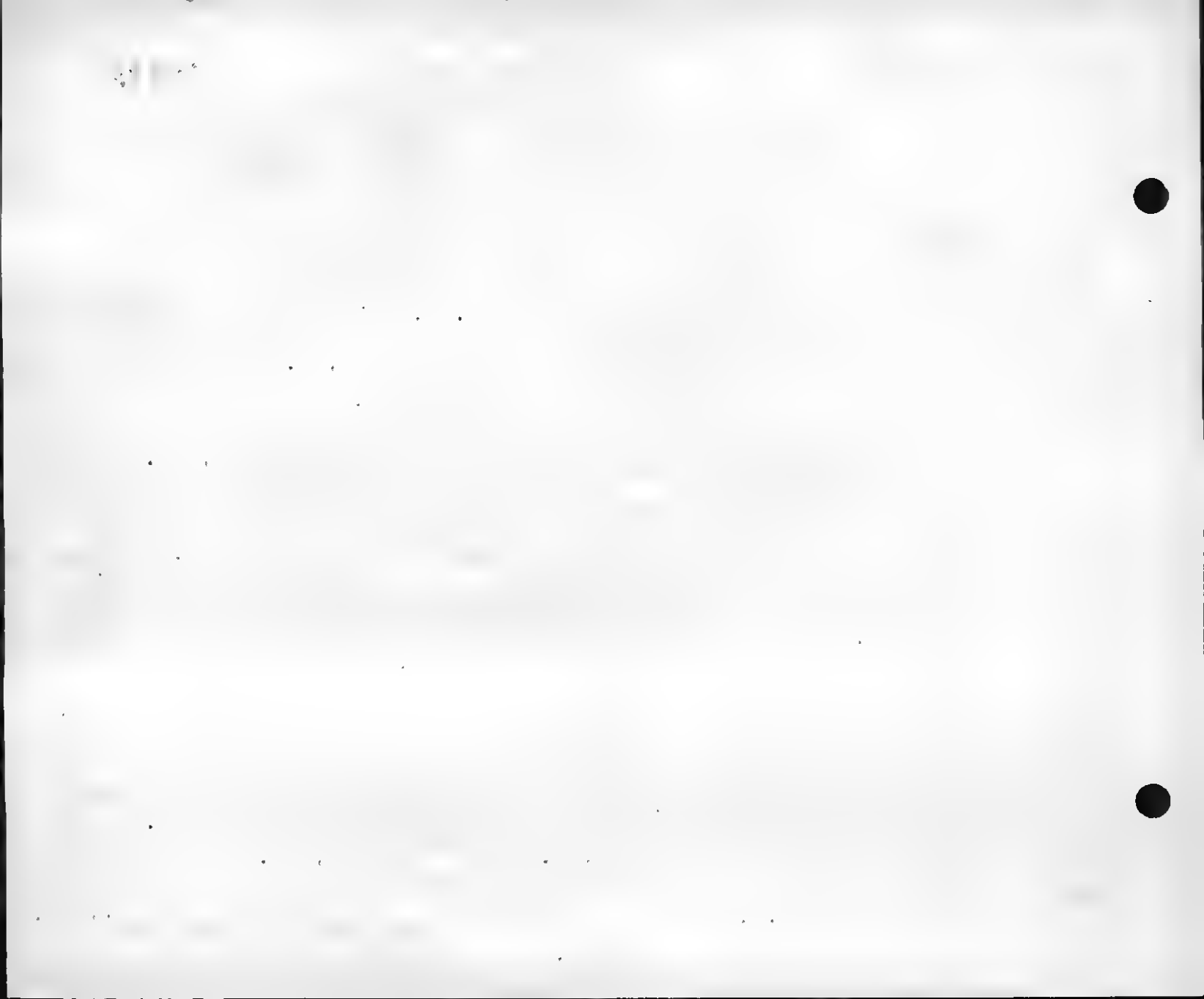
CERTIFICATE OF DEATH

15713

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Whiteford</b>		c. LENGTH OF STAY IN 1b <b>82 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Whiteford</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BRYAN</b> Middle <b>P.</b> Last <b>FORD</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 16, 1884</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Slate splitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Slate</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Whiteford, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Ford</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Allison</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>215-03-0426</b>		17. INFORMANT Address <b>Owen B. Ford, Whiteford, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1755X Congestive heart failure</b> DUE TO (b) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO (c) <b>And thrombosis of femoral left leg</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>10 years</b> <b>3 wk</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced pulmonary fibrosis + emphysema</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct</b> , 1958, to <b>Nov</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov</b> , 1966, and that death occurred at <b>9:15 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Edwin W. Whiteford, Jr.</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 2, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin W. Whiteford, Jr.</b>				22d. ADDRESS <b>Whiteford, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>		23d. LOCATION (City or town) (County) (State) <b>Delta York Co., Pa.</b>	
24. FUNERAL DIRECTOR <b>John H. Hawkins</b>				ADDRESS <b>Delta, Pa.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



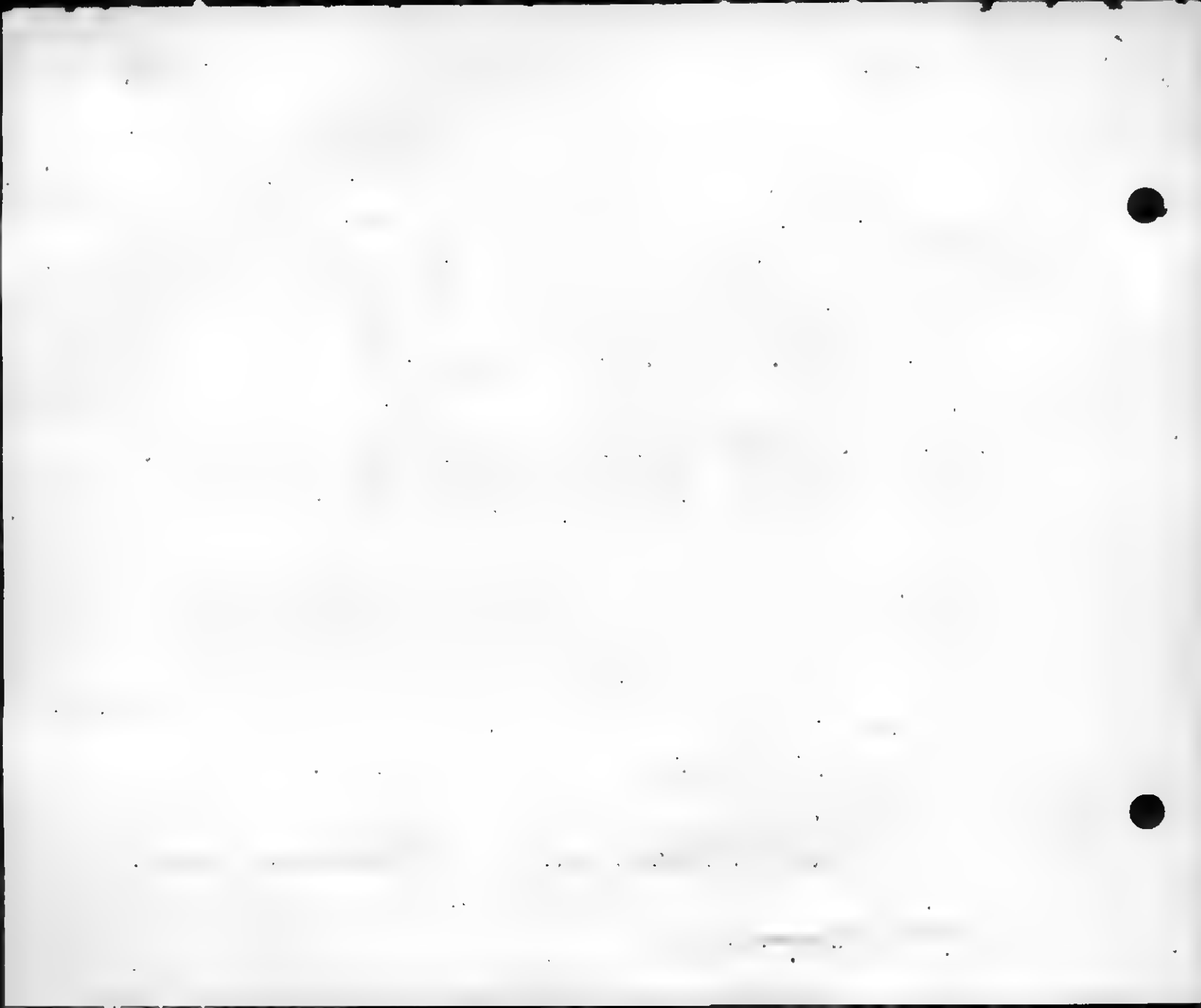
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
15712		15714									
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Proving Ground</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood, Maryland</u>				d. STREET ADDRESS <u>2407 Sycamore Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kirk Army Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>David</u>		First		Middle		Last		4. DATE OF DEATH <u>Nov 24 1966</u>		Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 Jan 28</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman (Pldg.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ord. Products</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sol Gerber</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Mar 46-66</u>		17. INFORMANT <u>Maryland State Patrol</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries pending completion of autopsy and toxicology studies</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car accident</u>							
20c. TIME OF INJURY Month, Day, Year <u>8:15</u> a.m. <u>Nov 24 66</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rte. 40</u>		20f. (City or town) (County) (State) <u>near Belcamp, Maryland</u> <u>Harford</u> <u>Md</u>			
21. I certify that (I) <u>Willis H. Stephens Jr</u> attended the deceased from <u>DOA</u> , <u>Nov 29 66</u> , 19 <u>66</u> , that (I) <u>DOA</u> last saw the deceased <u>DOA</u> , <u>24 Nov 1966</u> , and that death occurred at <u>8:15</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Willis H. Stephens Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>25 Nov 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIS H. STEPHENS, CPT., MC</u>				22d. ADDRESS <u>Kirk Army Hospital, APG, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Willis H. Stephens Jr</u>				ADDRESS <u>Tarring Funeral Home, Aberdeen, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15713

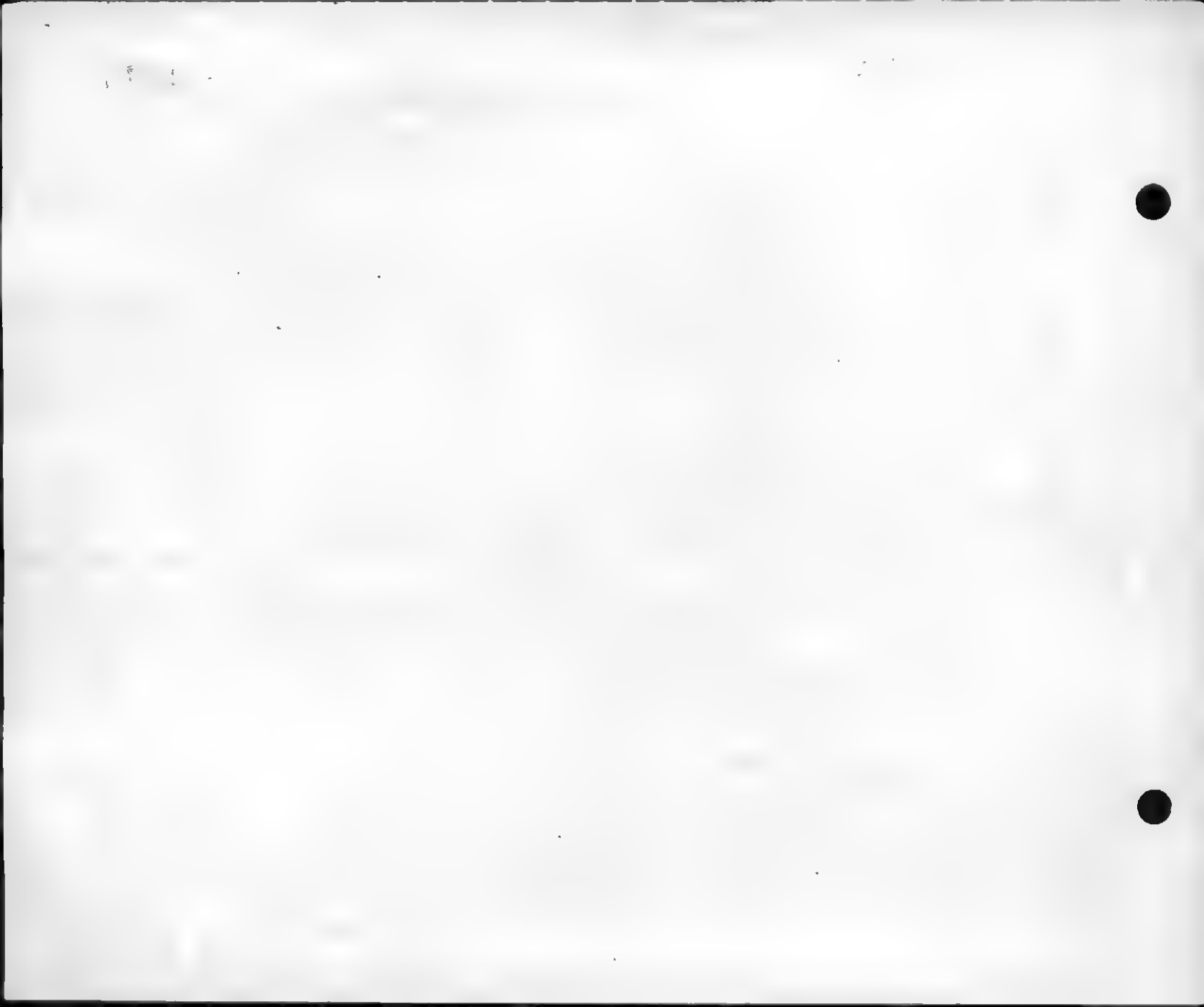
## CERTIFICATE OF DEATH

15715

1 PLACE OF DEATH a COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>MARYLAND</u> b COUNTY <u>HARFORD</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c LENGTH OF STAY IN Id <u>9 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hospital</u>		d. STREET ADDRESS <u>Willoughby Beach Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>ROSA</u> First <u>MARIE</u> Middle <u>GUNTHER</u> Last		4. DATE OF DEATH <u>November 2</u> 19 <u>66</u> Month Day Year	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 4, 1907</u>
9 AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Brewood, Harford Co., Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Morris M. Coulter</u>		14 MOTHER'S MAIDEN NAME <u>Emma Bunce</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>217-52-7522 T</u>	
17 INFORMANT Address <u>Mrs. Florence Spearman, Brewood, Md.</u>			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO (b) <u>Rupture of diverticula of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>9 days</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I (a) <u>A. S. C. D. and Obesity</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-25</u> , 19 <u>66</u> to <u>11-2</u> , 1966, that (I) (we) last saw the deceased alive on <u>11-2</u> , 1966, and that death occurred at <u>9:22</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Edward C. Lee, M.D.</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <u>11/3/66</u>	
22c PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>		22d ADDRESS <u>Haure de Grace, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Nov. 5, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Joppa Harford Md</u>
24 FUNERAL DIRECTOR ADDRESS <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 4 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

15714

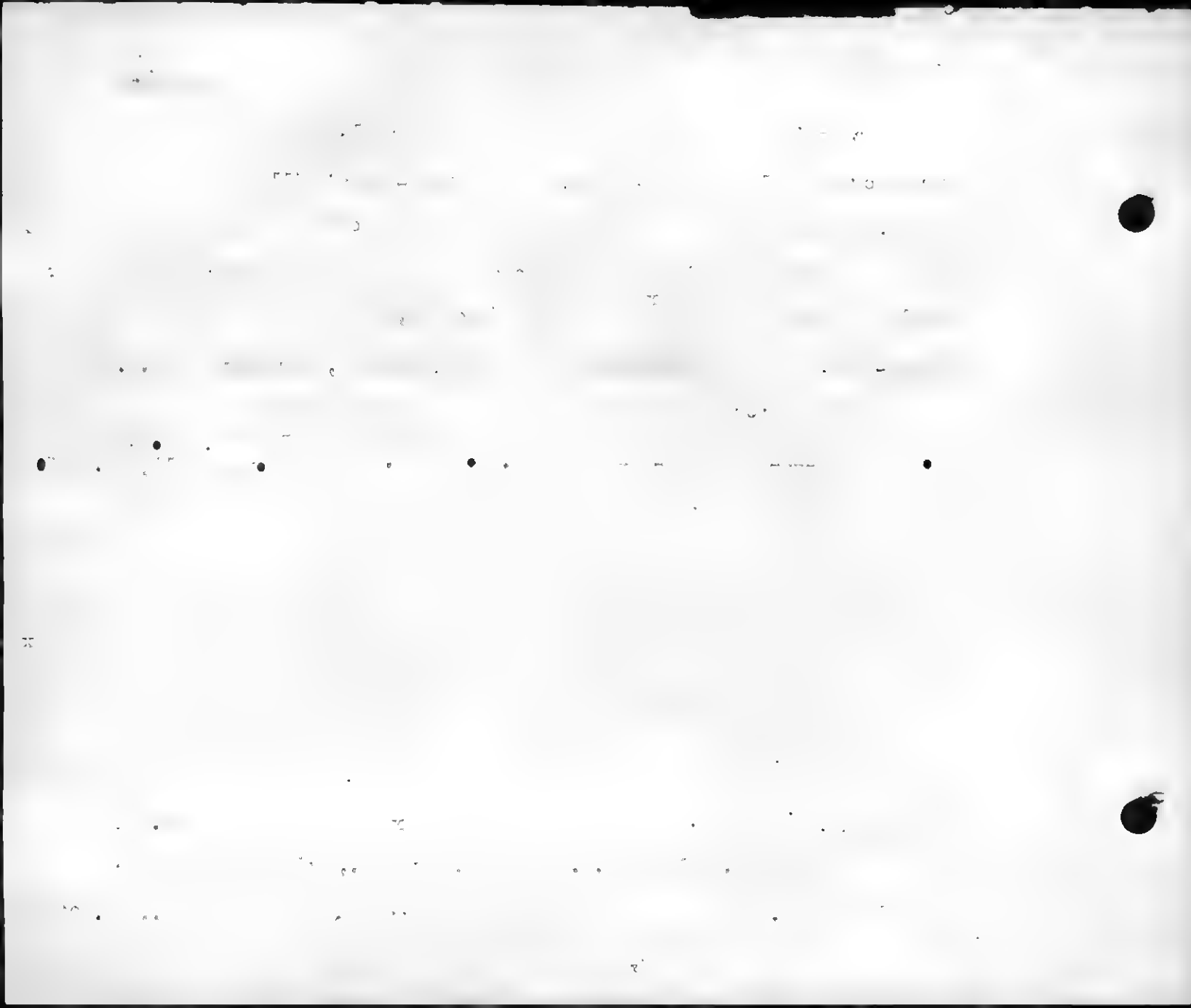
15716

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Forest Hill</b>				c. LENGTH OF STAY IN ID <b>40 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bynum Road</b>				d. STREET ADDRESS <b>Bynum Road</b>			
3. NAME OF DECEASED (Type or print) <b>Nancy Catherine Haga</b>				4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1898</b>	9. AGE (in years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager-Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Independence, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Fielden Isom</b>				14. MOTHER'S MARIEN NAME <b>Hattie Thorn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-18-5200A</b>		17. INFORMANT (Name, address, and relationship) <b>Mr. Robert G. Haga, Forest Hill, Md. 21050</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease (CVI)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>11-2</b> , 19 <b>66</b> , to <b>11-4</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11-2</b> , 19 <b>66</b> , and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Gerald C. Palmer</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 5, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>				22d. ADDRESS <b>S. Main St., Bel Air, Md. 21014</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION (City, town or county) _____ (State) _____			
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		W. Broadway & Williams Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR <b>NOV 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Joseph William Foster

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# MARYLAND STATE DEPARTMENT OF HEALTH

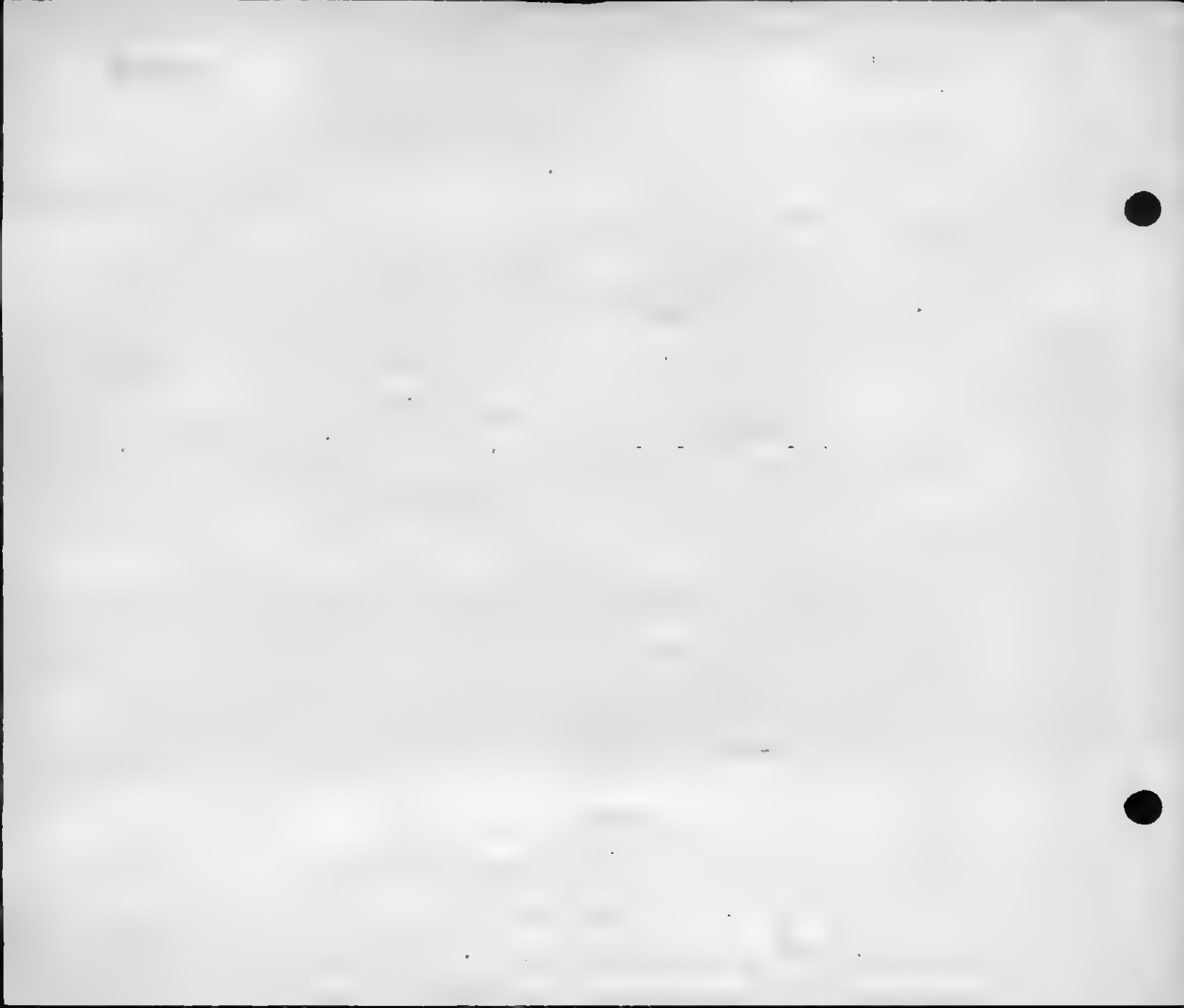
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15715

15717

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutledge</u>		c. LENGTH OF STAY IN TB <u>76 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutledge</u>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Park Road</u>				d. STREET ADDRESS <u>Park Road</u>			
3. NAME OF DECEASED (Type or print) <u>George Leo Hanlon</u>				4. DATE OF DEATH November 25, 1966			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 2, 1890	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rutledge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hanlon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dalton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-36-2415</u>			
17. INFORMANT <u>Mrs. Ethel Lynch</u>				18. ADDRESS <u>Federal Hill Road Rocks, Md. 21141</u>			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Probable Acute Myocardial Infarction</u>							
DUE TO (b) <u>  </u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>unknown</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <u>None</u>			
21c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		21f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>4/5</u> 19 <u>66</u> , to <u>4/5</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/5</u> 19 <u>66</u> , and that death occurred at <u>10:AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>James F. White, Jr. - at direction of</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Gerald Palmer</u>				22d. ADDRESS <u>Jarrettsville, Md. 21084</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/28/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Hyde Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15716

CERTIFICATE OF DEATH

15718

1. PLACE OF DEATH a COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>HARFORD</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hardee de Grace</u>		c LENGTH OF STAY IN 1b <u>30 days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Harford Memorial Hospital</u>				d STREET ADDRESS <u>Rt #1 320 Balt. Pike</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Worthington</u> Last <u>Hopkins</u>				4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 7, 1898</u>		9. AGE (In years last birthday) <u>68</u> yrs	f UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>		11. BIRTHPLACE (County & State or foreign country) <u>DARLINGTON, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD C. HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH OBERLANDER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>214-34-4467</u>		17. INFORMANT Address <u>Mrs. Ernest Henry, Whiteford, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Perforation of stomach</u> (c) <u>Linitis plastica</u> 3 weeks						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 26</u> , 19 <u>66</u> , to <u>Nov 25</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Nov 25</u> , 19 <u>66</u> , and that death occurred at <u>2 P.</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>James M.C. Finney</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>11-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES M.C. FINNEY</u>				22d. ADDRESS <u>HARDEE DE GRACE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Nov. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>		23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, HARFORD MD.</u>	
24. FUNERAL DIRECTOR <u>John H. Harlin, DELTA, PA.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 30 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

966

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

15717

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15719

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pro Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. LENGTH OF STAY IN 1b <u>46 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		d. STREET ADDRESS <u>13223 Ingleside Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>DOA Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dale C. Hudgins</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21-1933</u>	9. AGE (In years last birthday) <u>33</u>	10. UNDER 24 HRS Months <u>3</u> Days <u>3</u> Hours <u>33</u> Min <u>33</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>10. of Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Trenton N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Chesnut</u>				14. MOTHER'S MAIDEN NAME <u>Helen H. Akell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>10-000000000</u>		17. INFORMANT Address <u>Frank Chesnut Yorking Pa</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture SKULL</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto accident, auto-pulverizer</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Nov. 11 1966</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>		20f. (City or town) (County) (State) <u>Perryville Cecil Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Lerald C. Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bea Air, md.</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer - md</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>11-12-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Nov 16, 1966</u>		23c. NAME OF <u>Crematory</u> OR CREMATORY <u>Ft Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15718

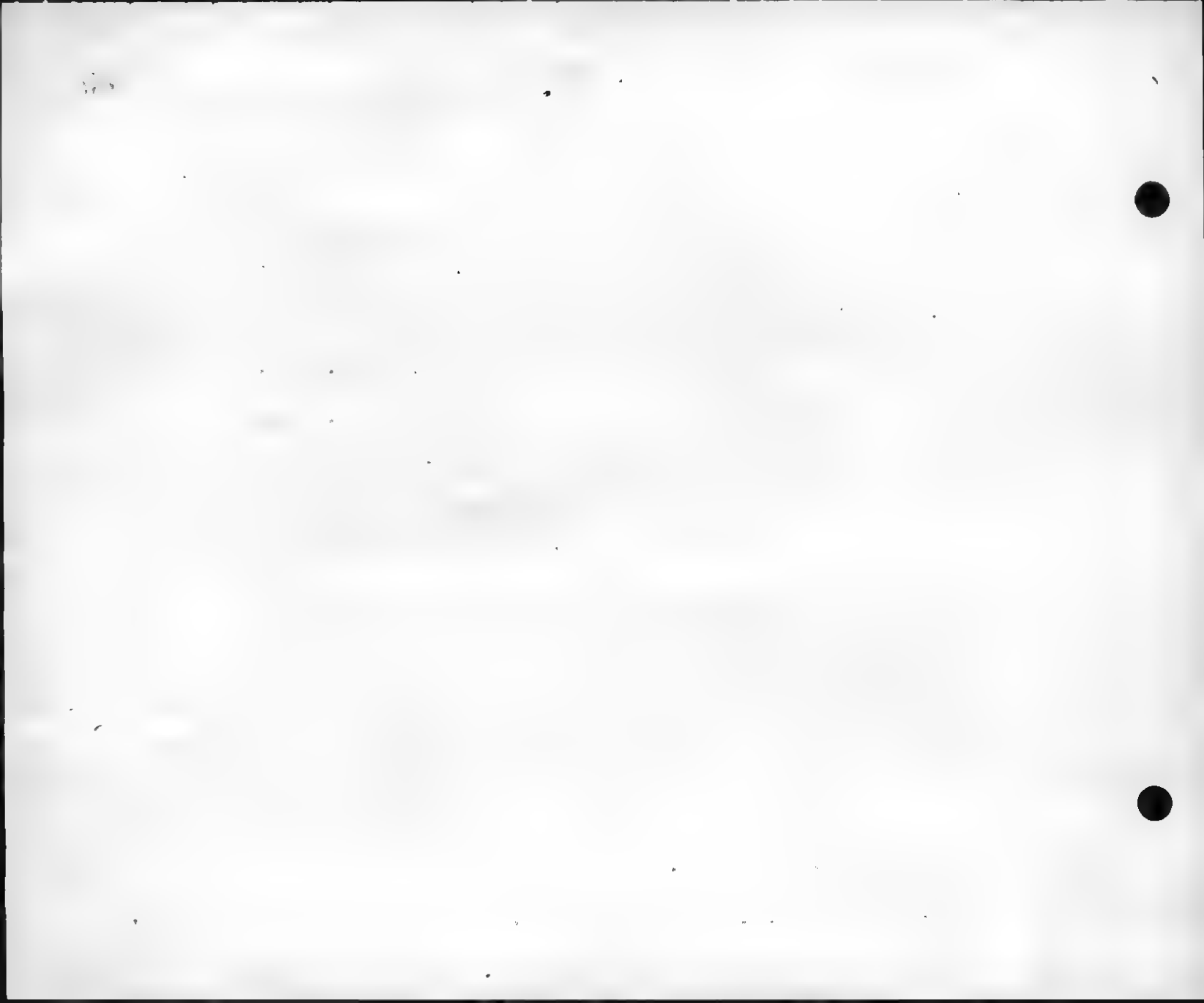
## CERTIFICATE OF DEATH

15720

1 PLACE OF DEATH a COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>HARFORD</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>HAURE de GRACE</u>		c LENGTH OF STAY in 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d STREET ADDRESS <u>377 Wilson St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>JACKSON</u>		4 DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Colored</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-3-66</u>
9 AGE (in years lost birthday) yrs <u>6</u> Mns <u>45</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Alvin Jackson</u>	
14 MOTHER'S MAIDEN NAME <u>Celma D. Jackson Fisher</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO. <u>None</u>		17 INFORMANT Address <u>Mother--Same as 2 C &amp; D</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>(4 months Uterine Gestation)</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>11/3</u> , 19 <u>66</u> , to <u>11/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-3</u> 19 <u>66</u> , and that death occurred at <u>11:5</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>C. Chan, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED <u>11/4/66</u>
22c PHYSICIAN'S NAME (Type) <u>C. Chan, M.D.</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>11-5-66</u>	<u>Union A.M.E. Cemetery</u>	<u>Aberdeen, Md.</u>
24 FUNERAL DIRECTOR <u>Charles Judge</u>		25a REC'D BY REGISTRAR <u>NOV 7 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15719

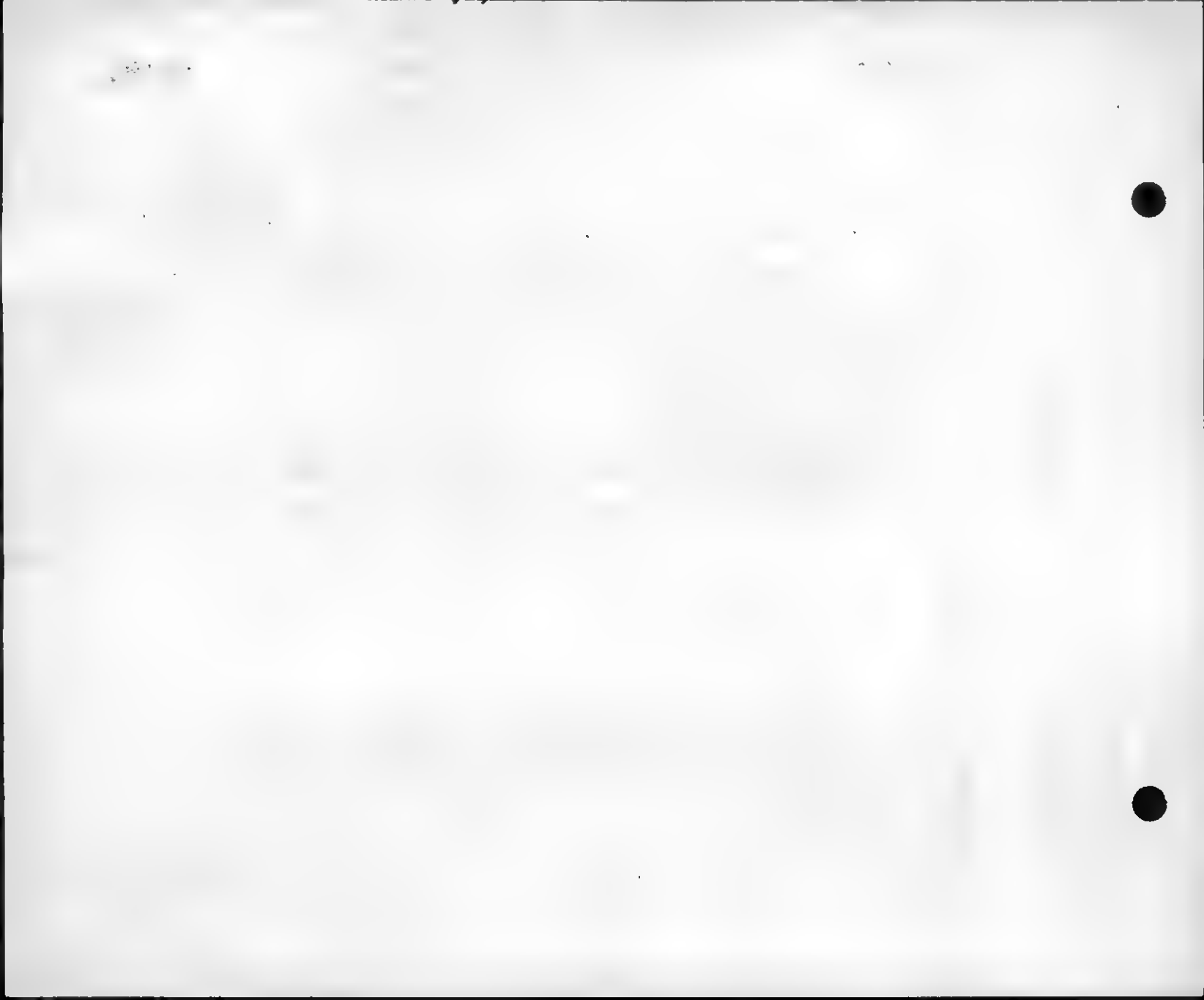
CERTIFICATE OF DEATH

15721

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> c. LENGTH OF STAY IN TB <u>19 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u> d. STREET ADDRESS <u>107 ALTON AVE.</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>MARK ALAN Johnson</u>		4 DATE OF DEATH Month Day Year <u>November 13 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-14-63</u>
9 AGE (In years lost birthday) <u>3</u>		10 IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13 FATHER'S NAME <u>Carl Edward Johnson</u>		14 MOTHER'S MAIDEN NAME <u>Doris E. King</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO. <u>none</u>	
17 INFORMANT <u>Carl Edward Johnson, 107 Alton Ave.,</u>		Address <u>Abingdon, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration and ileus</u> DUE TO (b) <u>Septicemia</u> DUE TO (c) <u>lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>20 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>66</u> , to <u>Nov 13</u> , 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>11-13</u> 19 <u>66</u> and that death occurred at <u>7<sup>00</sup></u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yuen</u>		22b. DATE SIGNED <u>11/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUEN</u>		22d. ADDRESS <u>HARFORD de GRACE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 16, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford MD</u>
24. FUNERAL DIRECTOR <u>Edward K. McGonag</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

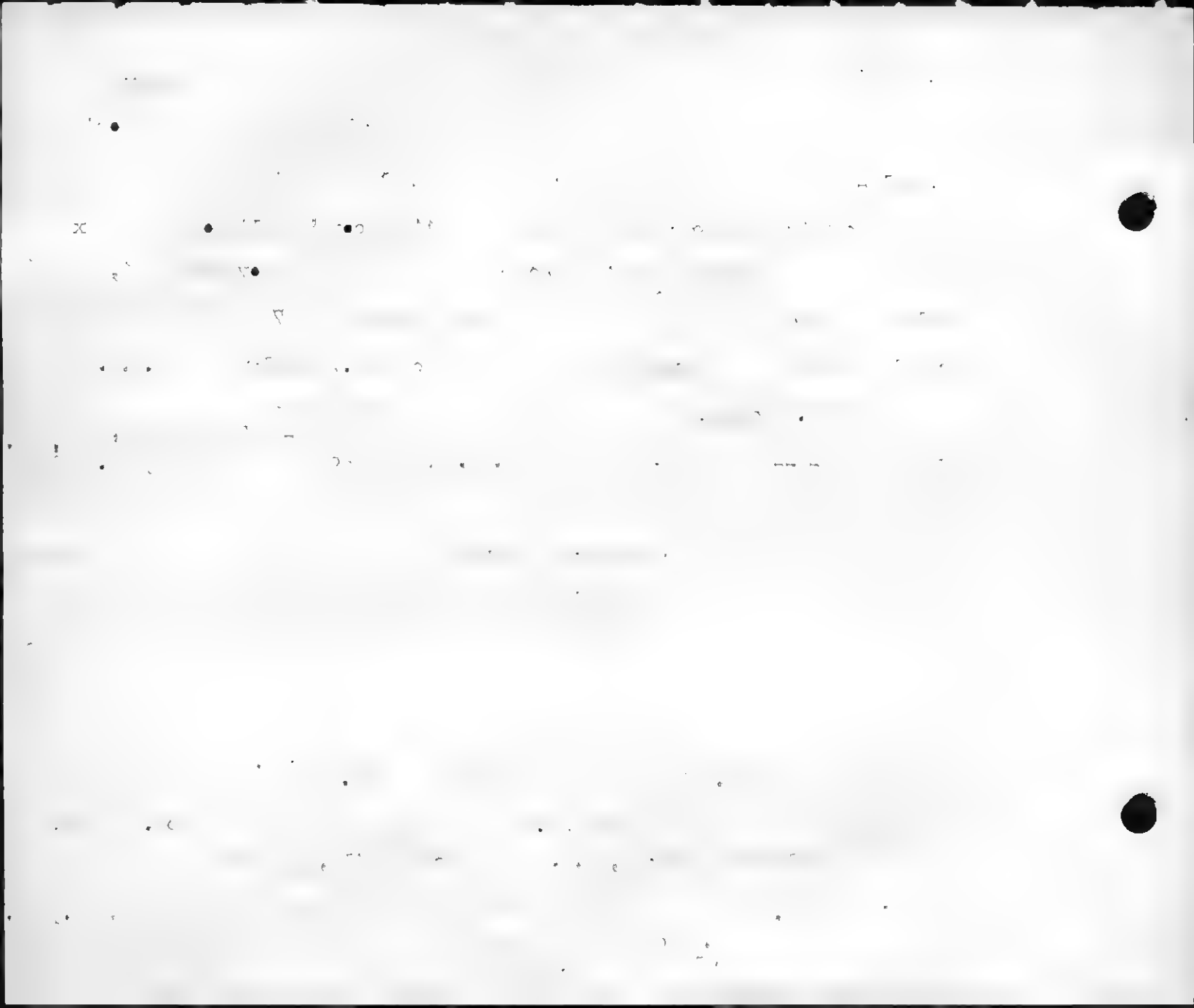
15720

15722

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b> c. LENGTH OF STAY IN 1b <b>32 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Moore's Mill Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b> d. STREET ADDRESS <b>1110 Moore's Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>May</b> Last <b>Jones</b>			4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>March 26, 1899</b>		9. AGE (in years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel W. Thompson</b>					
14. MOTHER'S MAIDEN NAME <b>Anna Parker</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>----</b>					
16. SOCIAL SECURITY NO. <b>219-34-2574</b>		17. INFORMANT (Husband) <b>838-5357</b> Address <b>1110 Moore's Mill Rd. Bel Air, Md. 21014</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>534X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Right side hemiplegia</b> DUE TO (c) <b>Cerebral vascular disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>3 months</b> <b>?</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>June 1, 1963</b> to <b>Nov. 1, 1966</b> , that (I) <del>and</del> last saw the deceased alive on <b>Oct. 31, 1966</b> , and that death occurred at <b>6 A.</b> M. from the causes and on the date stated above.					
22a. SIGNATURE <b>Willard P. Hudson</b>		22b. DATE SIGNED <b>Nov. 1, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>			
22d. ADDRESS <b>Forest Hill, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>Nov. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Meth. Ch. Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Fountain Green, Harf. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Joseph William Foster

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

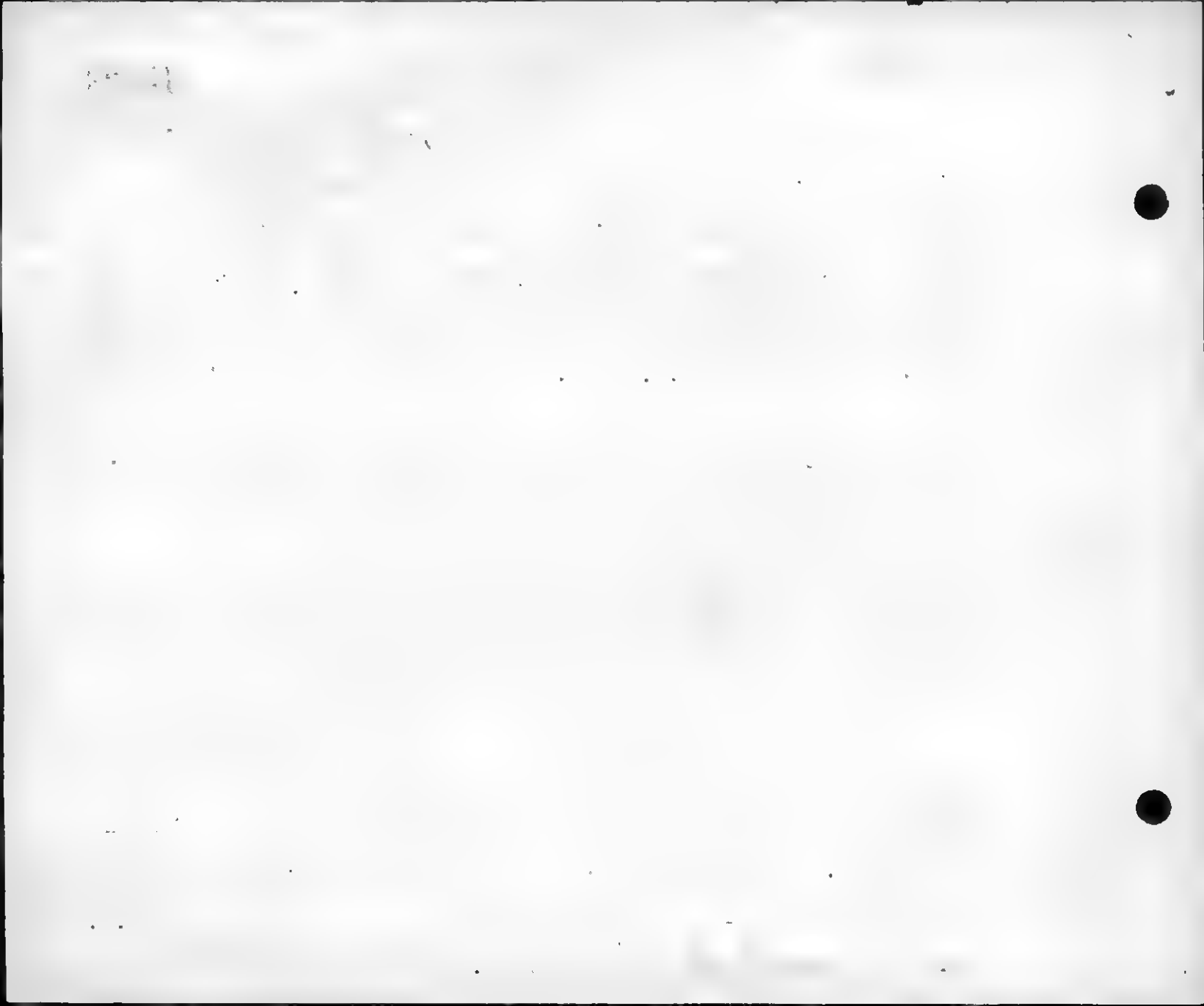
15721

Items 8,9 10,11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59,60,61,62,63,64,65,66,67,68,69,70,71,72,73,74,75,76,77,78,79,80,81,82,83,84,85,86,87,88,89,90,91,92,93,94,95,96,97,98,99,100

CERTIFICATE OF DEATH

15723

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUGS DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>12 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		e. STREET ADDRESS <u>RD 1 Box 158</u>	
3 NAME OF DECEASED (Type or print) <u>SANFORD</u> <u>NOAH</u> <u>LYALL</u>		4 DATE OF DEATH Month <u>November</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/09</u>
9. AGE (in years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artl. Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. EMP</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Ashe Co., N.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Thomas Lyall</u>		14. MOTHER'S MAIDEN NAME <u>Martha Alice Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW-II</u>		16 SOCIAL SECURITY NO <u>245-03-0160</u>	
17 INFORMANT <u>Lillian Lyall, Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>massive gastrointestinal hemorrhage</u> DUE TO <u>duodenal ulcer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Carcinoma head of pancreas &amp; liver metastases</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 month</u> <u>1 year</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>Nov 18, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov. 18</u> 19 <u>66</u> , and that death occurred at <u>8:30 A</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J. Ralph Horky</u>		22b. DATE SIGNED <u>11-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky, M.D.</u>		22d. ADDRESS <u>X</u> <u>Churchville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>11-20-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Big Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Jefferson, N.C.</u>	
24 FUNERAL DIRECTOR <u>Whitely McCumber Sr.</u>		25a. ADDRESS <u>Funeral Home, Aberdeen, Md.</u>	
25b. REC'D BY REGISTRAR <u>NOV 21 1966</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

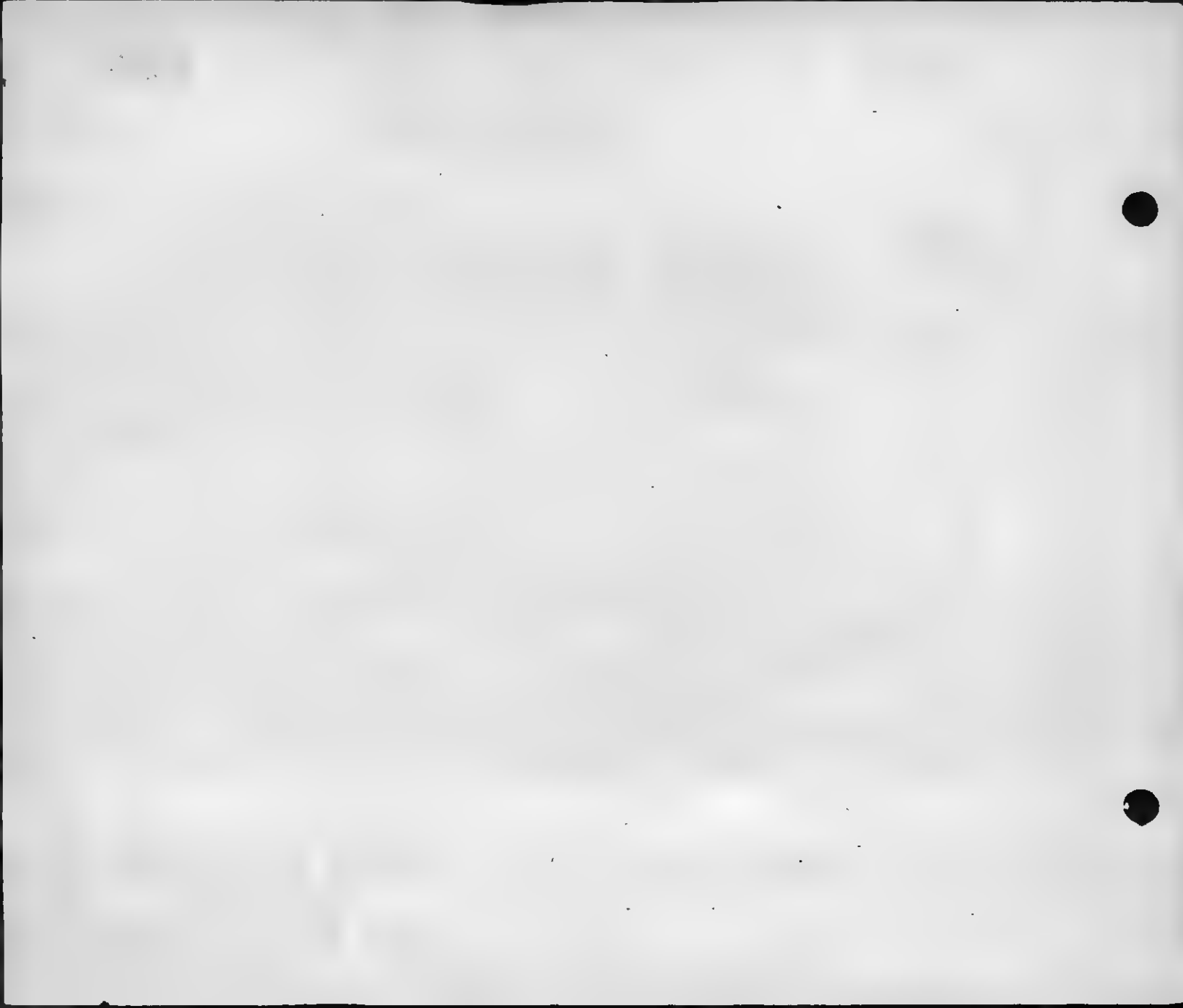
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15722

15725

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL-HAYRE DE GRACE</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL-HAYRE DE GRACE MD</b>			
c. LENGTH OF STAY IN b. <b>60 YRS</b>				d. STREET ADDRESS <b>R.D. #2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #2</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA ALBERDA OSBORN</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 7 1882</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>BENJAMIN HARTINS</b>			
14. MOTHER'S MAIDEN NAME <b>EMMA JONES</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>—</b>			
16. SOCIAL SECURITY NO. <b>—</b>				17. INFORMANT <b>GEORGE L OSBORN, HAYRE DE GRACE MD. #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Old age</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 30, 1966</b> to <b>Nov 1, 1966</b> that (I) (we) last saw the deceased alive on <b>Nov 1, 1966</b> and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Yun</b> M.D.				22b. DATE SIGNED <b>11/2/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. YUN</b>				22d. ADDRESS <b>HAYRE de GRACE MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESLEYAN CHAPEL</b>		23d. LOCATION (City, town or county) (State) <b>HARFORD Co. MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b>				25. REC'D BY REGISTRAR <b>Nov 7 1966</b>			
26. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							



MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15723

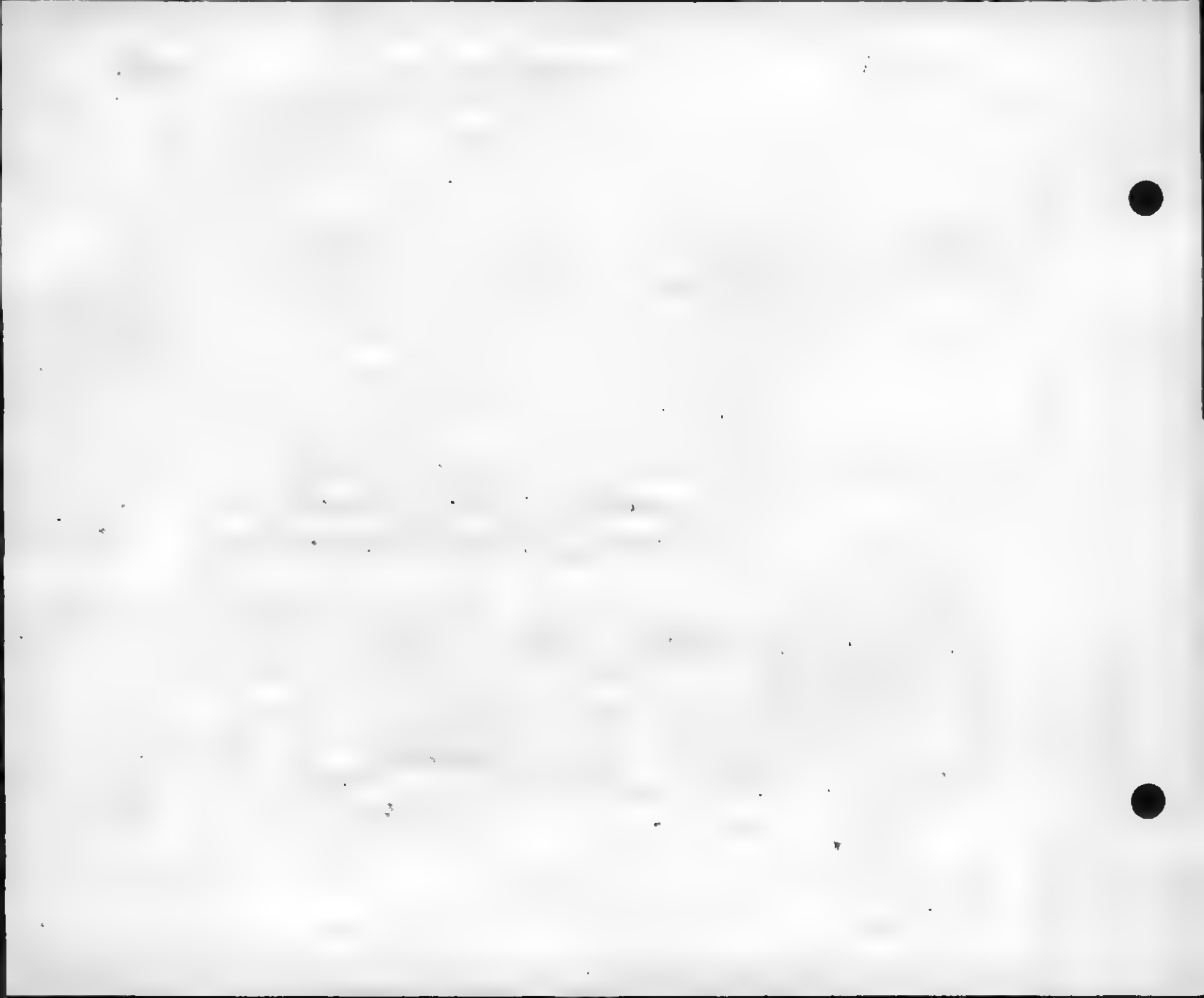
**CERTIFICATE OF DEATH**

15726

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baldwin</b>		c LENGTH OF STAY IN 1b <b>25 yrs</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fork Road</b>		d STREET ADDRESS <b>Fork Road Baldwin, Md. 21013</b>	
3 NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Henry</b> Last <b>Flowman</b>		4 DATE OF DEATH Month <b>11</b> Day <b>7</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1906</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Planner</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Martin Marietta</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
13 FATHER'S NAME <b>Elmer F. Flowman</b>		14 MOTHER'S MAIDEN NAME <b>Anna Zippling</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>212-01-2416</b>	17 INFORMANT Address <b>21013</b> <b>Mrs Inez Flowman Fork Road Baldwin, Md.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>47:1</b> DUE TO <b>Hypertensive Cardiac Dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>6 yrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Renal Calculus; Obesity</b>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>6/21/65</b> to <b>11/7</b> , 1966 that (I) (we) last saw the deceased alive on <b>Nov. 7, 1966</b> and that death occurred at <b>1:40 P.M.</b> from causes and on the date stated above.			
22a SIGNATURE <b>Clifford F. Hudson</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b DATE SIGNED <b>11/8/66</b>
22c PHYSICIAN'S NAME (Type) <b>CLIFFORD F HUDSON</b>		22d ADDRESS <b>FORK, MD</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>11-10-1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	23d. LOCATION (City or Town) _____ (County) _____ (State) <b>Baltimore Md.</b>
24 FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Road</b>		ADDRESS <b>(36)</b>	25a REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

15724

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15727

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Hill</b> 12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sharon Acres Road</b>		d. STREET ADDRESS <b>Sharon Acres Road</b>	
3. NAME OF DECEASED (Type or print) First <b>GUY</b> Middle <b>PRITT</b> Last <b>PRITT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/1925</b>
9. AGE (In years last birthday) <b>41</b> yrs		10. UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>12</b> Min <b>12</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gasper Pritt</b>		14. MOTHER'S MIDDLE NAME <b>Pattee Rose</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-34-4176</b>	
17. INFORMANT <b>Mrs Arlen Pritt</b>		Address <b>Sharon Acres Rd Forest Hill Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Diffuse fibrinopurulent peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Perforated gastric ulcer</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Underdetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		22. DATE SIGNED <b>November 18, 1966</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>11/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Philip's Herwig Sons 2024 Calverton St</b>		23d. LOCATION (City or Town) (County) (State) <b>Brownsville W. Virginia</b>	
24. FUNERAL DIRECTOR <b>Philip's Herwig Sons</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15725

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

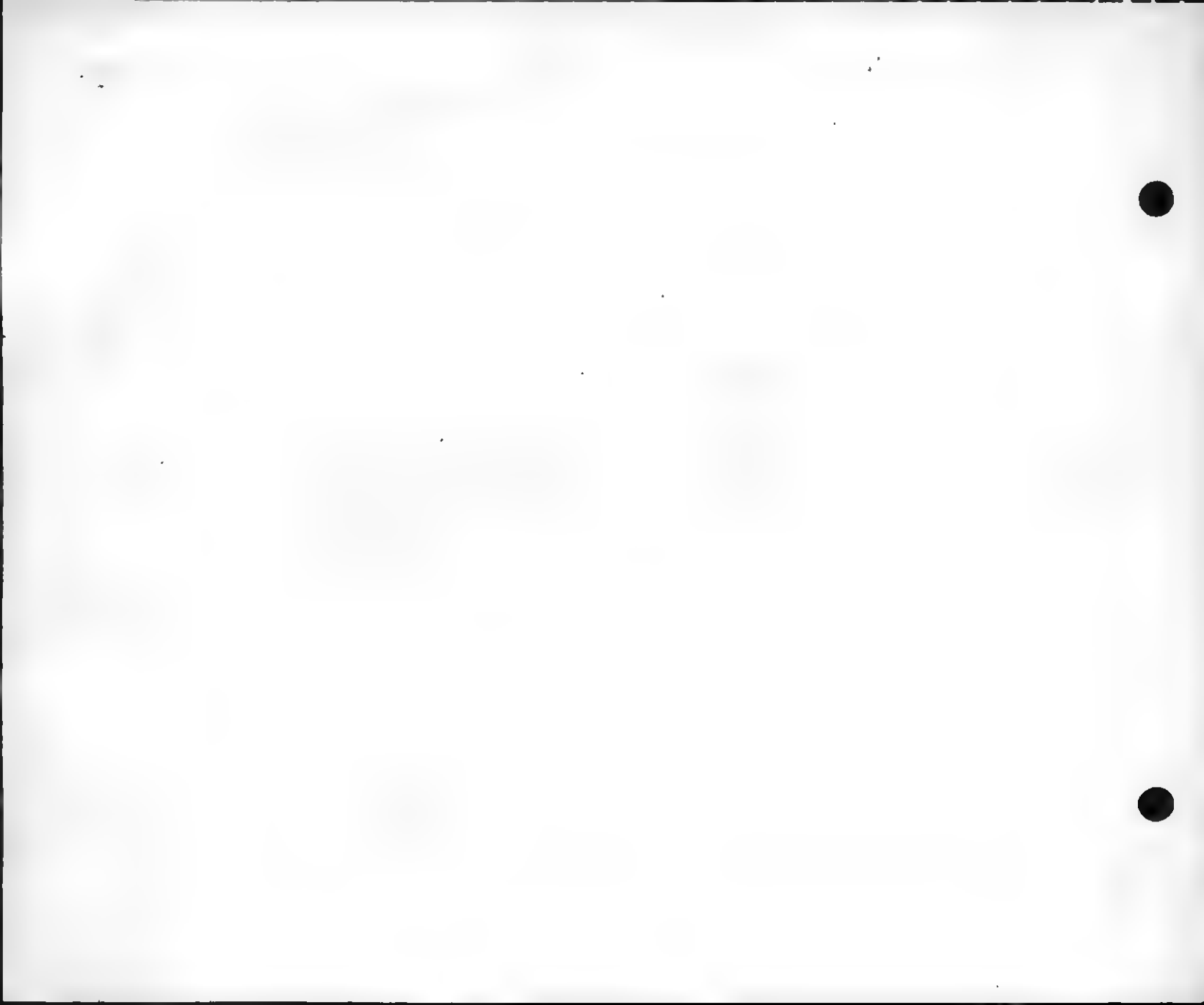
15728

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air (Rural)</u>		c. LENGTH OF STAY IN 1b <u>12.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Churchville Road</u>		d. STREET ADDRESS <u>219 W. Thomas St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Pruitt</u>		4. DATE OF DEATH Month <u>November</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-43</u>
9. AGE (In years lost birthday) yrs <u>23</u>		IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u> Hours <u>23</u> Min <u>23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assistant Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Variety Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Wilkes Co., N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aldine Pruitt</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Wanda Pardue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>244-62-4073</u>	
17. INFORMANT (with) <u>838-6374</u> Address <u>2201, Box 382C, Fallston, Maryland 21047</u>		Mrs. Mary Lee Pruitt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to CO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DU TO</u> (c) <u>DU TO</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOLPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Pipet exhaust into car</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> Hour <u>PM</u> <u>11-12</u> <u>1966</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Churchville Rd</u>	20f. (City or town) (County) (State) <u>Bel Air</u> <u>Hartford</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lorena E. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-12-66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or town) (County) (State) <u>Bel Air, Hartford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway &amp; Williams St.</u> <u>Bel Air, Maryland 21014</u>		NOV 14 1966 DATE	
		25. REGISTRAR'S SIGNATURE <u>Charles J. Jurek</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15726

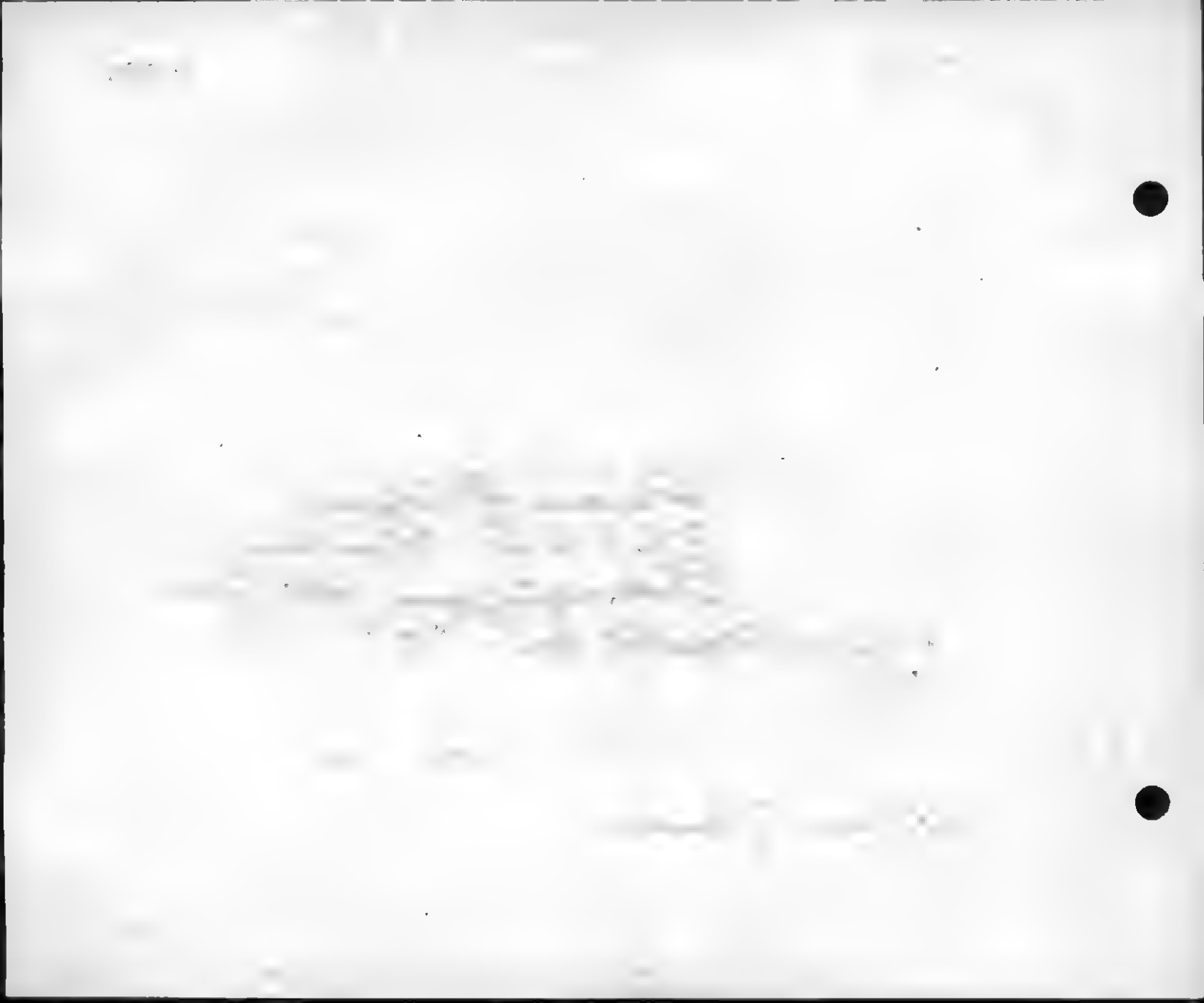
## CERTIFICATE OF DEATH

15729

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Harre de Grace</b>		c. LENGTH OF STAY in 1b <b>10 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>		d. STREET ADDRESS <b>RFD R Box 30</b>	
3. NAME OF DECEASED (Type or print) <b>Maud Virginia Roberts</b>		4. DATE OF DEATH <b>November 27 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14, 1890</b>
9. AGE (In years lost birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>VA.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. FATHER'S NAME <b>R. H. Sawyers</b>		16. MOTHER'S MAIDEN NAME <b>Eliza J. Huddleston</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO <b>212-32-4622</b>	
19. INFORMANT (Son) <b>838-6139</b> Address <b>Mc. Onnie K. Roberts RFD #2 Box #30 Bel Air, Maryland 21014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 515X DUE TO <b>Q.S.C.U.A. - Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Chloroform poisoning - early Fisher</b> (c) <b>Chloroform poisoning - early Fisher</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE CONDITION GIVEN IN PART I (a) <b>11/22/66 Asphyxiated for "C"</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-18</b> , 19 <b>66</b> , to <b>Nov 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 27, 1966</b> , and that death occurred at <b>12:40</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wm. K. Brendle</b> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>11/27/66</b>
22c. PHYSICIAN'S NAME (Type) <b>William K. Brendle, M.D.</b>		22d. ADDRESS <b>Harre de Grace, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>December 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Summerfield Meth. Ch. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Fries, Grayson Co. Virginia</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> ADDRESS <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

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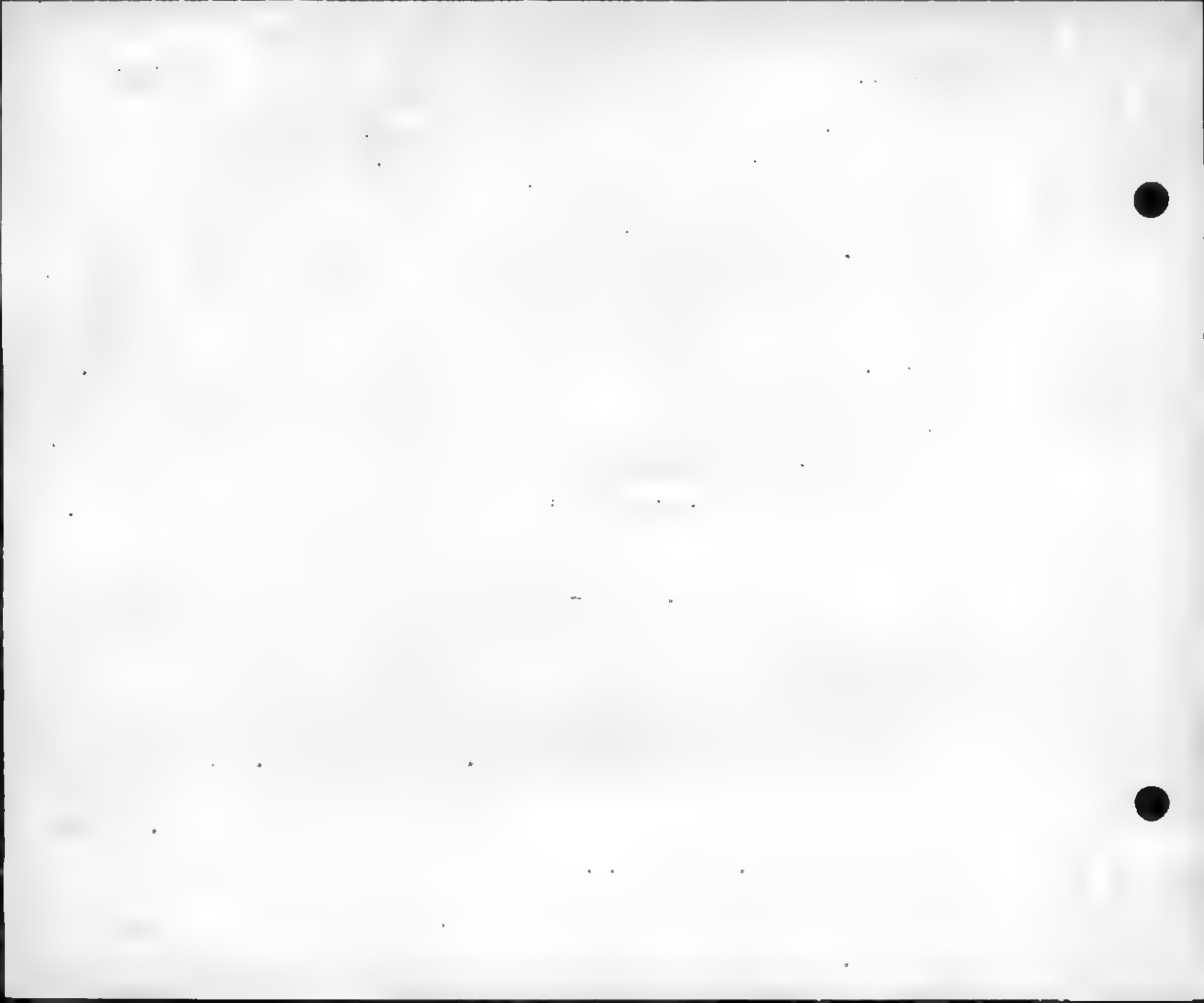
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15727

CERTIFICATE OF DEATH

15730

1 PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL DE GRACE</u>		c. LENGTH OF STAY IN 'b <u>2 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>Federal Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JAMES CLARENCE ROBINSON</u> First Middle Last				4 DATE OF DEATH <u>November 25</u> 19 <u>66</u> Month Day Year			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/17/1887</u>		9. AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Quarry</u>		11. BIRTHPLACE (County & State or foreign country) <u>Fallston, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd BARNES ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Rainbow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>218-12-4084</u>		17. INFORMANT <u>Lrs. Grace A. Robinson</u> Address <u>Federal Hill Road, ROCKS, Md.</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia, chronic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Chr. Cardio-vascular Renal Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19,</u> 19 <u>66</u> to <u>Nov. 25,</u> 19 <u>66</u> , that (I) <u>did</u> lost saw the deceased alive on <u>11-25-66</u> 19 <u>66</u> , and that death occurred at <u>1:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Willard P. Hudson</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Nov. 26, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				22d. ADDRESS <u>Forest Hill, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/29/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. James M.E.</u>		23d. LOCATION (City or Town) (County) (State) <u>Federal Hill, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>				ADDRESS <u>Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

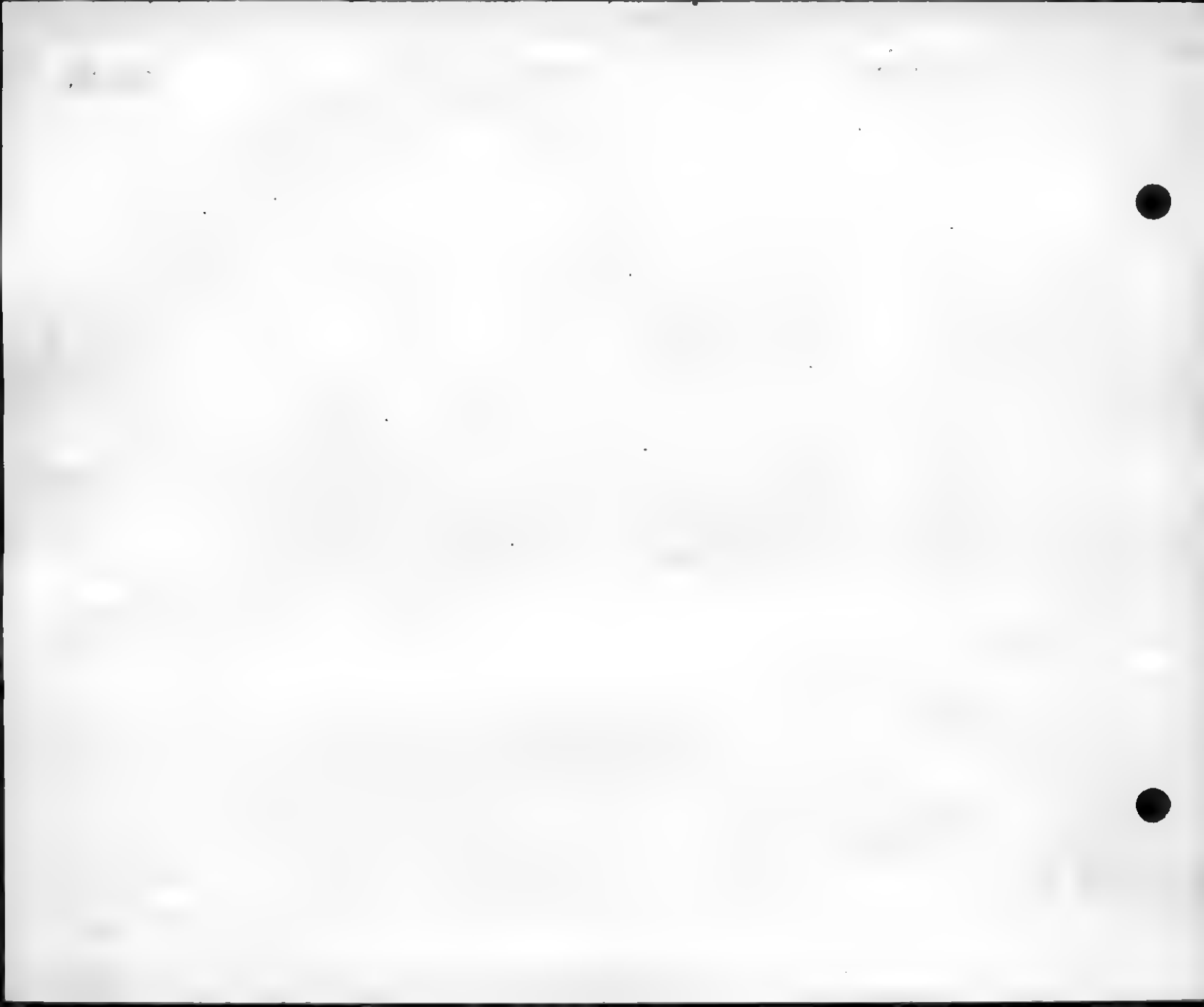
15728

15731

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md</u> b COUNTY <u>Hartford</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c LENGTH OF STAY in lb <u>2 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d STREET ADDRESS <u>Plum Tree Rd. Rd 3</u>	
3 NAME OF DECEASED (Type or print) <u>George William Rufenacht</u>		4 DATE OF DEATH <u>November 17 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 15, 1898</u>
9a AGE (in years last birthday) <u>68</u> yrs		9b IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ship Foreman</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Mfg Farm Equip</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md</u>		12 CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13 FATHER'S NAME <u>Herman Rufenacht</u>		14 MOTHER'S MAIDEN NAME <u>Sophia Pearce</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>218-18-0717</u>	
17 INFORMANT <u>William Rufenacht</u>		Address <u>913 Plumtree Rd. Bel Air Md</u>	
18 CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-pulmonary failure &amp; congestion</u> (b) <u>Hemorrhagic, metastatic Carcinoma of lung</u> (c) <u>62X</u> DUE TO last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 days 3 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15, 1966</u> to <u>Nov 17, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov. 17, 1966</u> , and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above.			
22a SIGNATURE <u>A.W. Grigoleit</u>		22b DATE SIGNED <u>11/17/66</u>	
22c PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>		22d ADDRESS <u>Havre de Grace Hartford Md</u>	
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Nov. 19, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Mountain Christian Cem</u>	23d LOCATION (City or Town) (County) (State) <u>Sopps Hartford Md</u>
24. FUNERAL DIRECTOR <u>W.H. Archer, Benson Md</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15723

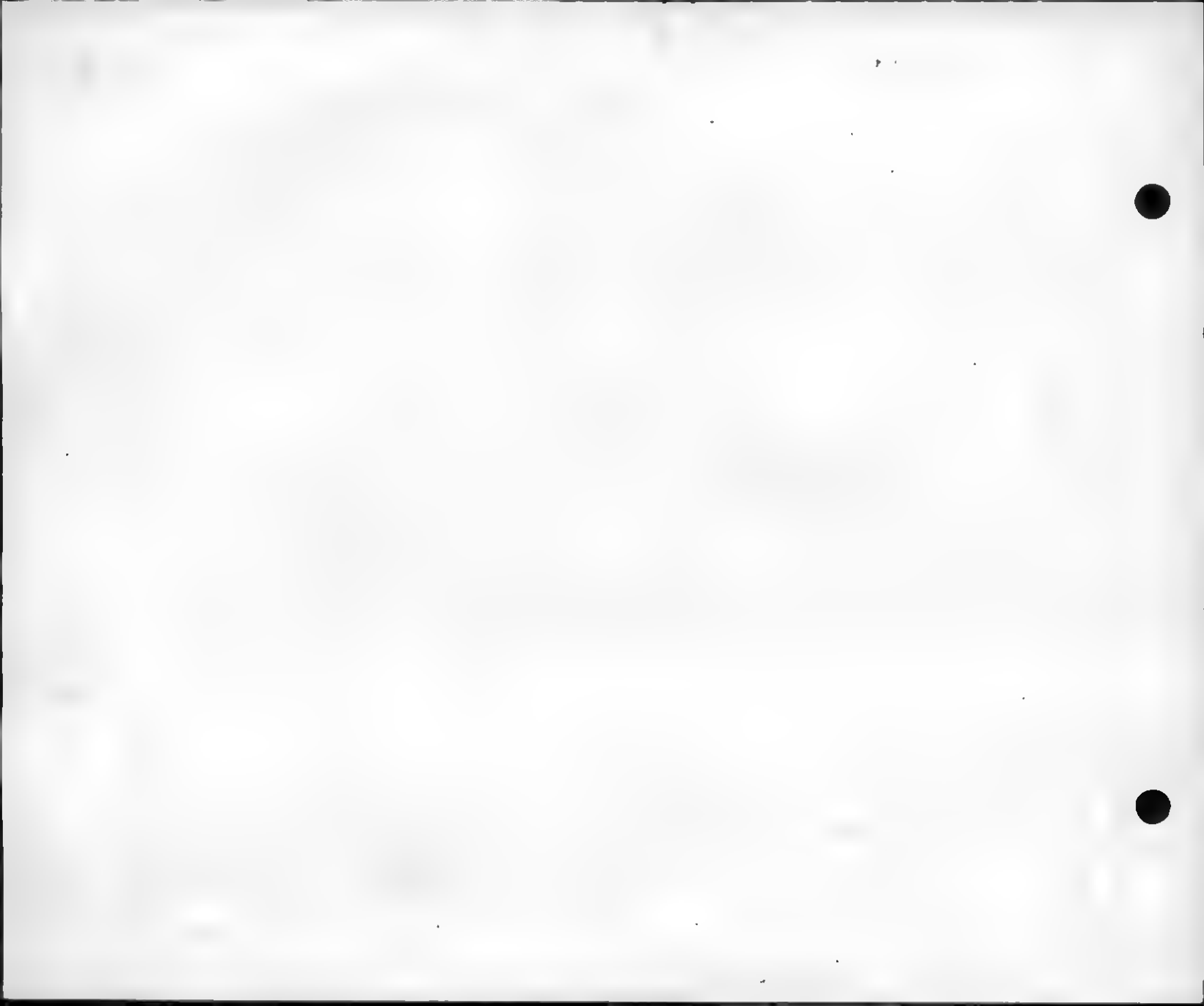
CERTIFICATE OF DEATH

15732

1 PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		d. STREET ADDRESS <u>728 South Union Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Otis Elmer Snyder</u>		4 DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 3, 1897</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADMINISTRATIVE ASST.</u>	11. BIRTHPLACE (County & State or foreign country) <u>Pa</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mr. Elmer P. Snyder - HARFORD, MD</u>	
17. INFORMANT <u>Mr. Elmer P. Snyder - HARFORD, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>3 days</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 3, 1966</u> to <u>Nov 5, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 5, 1966</u> and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>11/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HARFORD de GRACE, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>NOV. 3, 1966</u>	<u>WESTLAWN CEM.</u>	<u>HARFORD, Co. MD</u>
24. FUNERAL DIRECTOR <u>R. Madison Mathall, Harford Co., Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

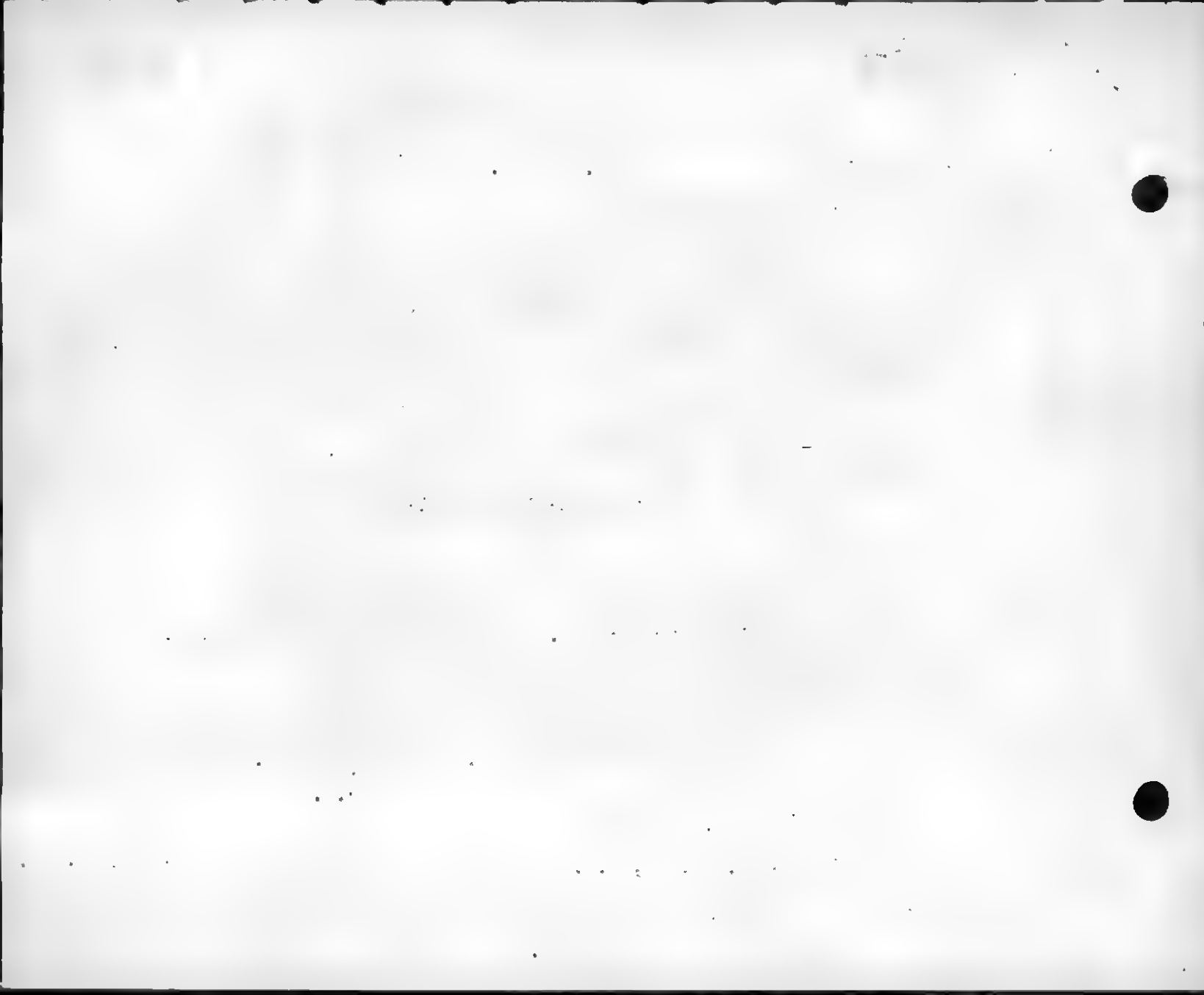


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Harford</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> <b>a. STATE</b> <u>Md</u> <b>b. COUNTY</b> _____							
<b>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</b> <u>Jarrettsville</u>				<b>c. LENGTH OF STAY IN 1b</b> <u>2 yrs. 10 mos.</u>				<b>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</b> <u>BALTIMORE</u>			
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <u>Samuel Bevard Nursing Home</u>				<b>d. STREET ADDRESS</b> <u>2017 McHenry St</u>				<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED (Type or print)</b> <u>THEODORE</u>				<b>4. DATE OF DEATH</b> First <u>THEODORE</u> Middle <u>SOMMERS</u> Last <u>SOMMERS</u> Month <u>November</u> Day <u>27</u> Year <u>1966</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 12, 1993</u>		<b>9. AGE (In years last birthday)</b> <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>hospital</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>hospital</u>				<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Gotlieb Sommer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Miss Helen Keeler - 2017 McHenry Park Md</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>212-32-1148</u>				<b>17. INFORMANT</b> <u>Miss Helen Keeler - 2017 McHenry Park Md</u>			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>Chronic Aleukemic leukemia</u> <u>2044</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 yrs?</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Generalized arteriosclerosis; chr. arteriosclerotic cardio-vascular disease</u>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)</b> <u>diagnosis</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <u>diagnosis</u>		<b>20f. (City or town) (County) (State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u>, 19<u>64</u> to <u>Nov. 27</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>11-17-66</u>, 19<u>66</u>, and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Willard P. Hudson</u>				<b>22b. DATE SIGNED</b> <u>Nov. 30, 1966</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Willard P. Hudson, M.D.</u>			
<b>22d. ADDRESS</b> <u>2323 Rock Spring Road, Forest Hill, Md.</u>				<b>22e. MED. PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Nov 30 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral Cn</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore Md</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Thomas J. Kenny, Inc 1600 Volins Balto. Md</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Nov 30 1966</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15734

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Hartford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Pa</u> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u>		c LENGTH OF STAY IN 1b <u>Ephrata</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d STREET ADDRESS <u>5275 State St</u>	
3 NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Stahl</u> Last		4 DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUNE 17, 1943</u>
9 AGE (In years last birthday) <u>23</u> yrs		10 IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u> Hours <u>00</u> Min <u>00</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>SHOE FACTORY WORKER</u>		10b KIND OF BUSINESS OR INDUSTRY <u>SHOE MFG.</u>	
11 BIRTHPLACE (State or foreign country) <u>EPHRATA, PA</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>IRVIN W. STAHL</u>		14 MOTHER'S MAIDEN NAME <u>CAROLINE SCHRINTZ</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOC. A. SECURITY NO.	
17 INFORMANT <u>Mrs. CAROLINE STAHL, Ephrata, Pa.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Fracture Pelvis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Auto Accident</u>	
20c TIME OF INJURY Month, Day, Year <u>3:26</u> a.m. <u>11-13-66</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f (City or town) (County) (State) <u>EPHRATA, LANCASTER, PA</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u>		22. DATE SIGNED <u>11-13-66</u>	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer - MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>11-13-66</u>	
23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE THEREOF <u>16 Nov. 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>EPHRATA</u>	23d LOCATION (City or town) (County) (State) <u>EPHRATA, LANCASTER, PA</u>
24 FUNERAL DIRECTOR <u>William H. Hamer, Jr., MD</u>		25a REC'D BY REGISTRAR DATE <u>NOV 15 1966</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15732

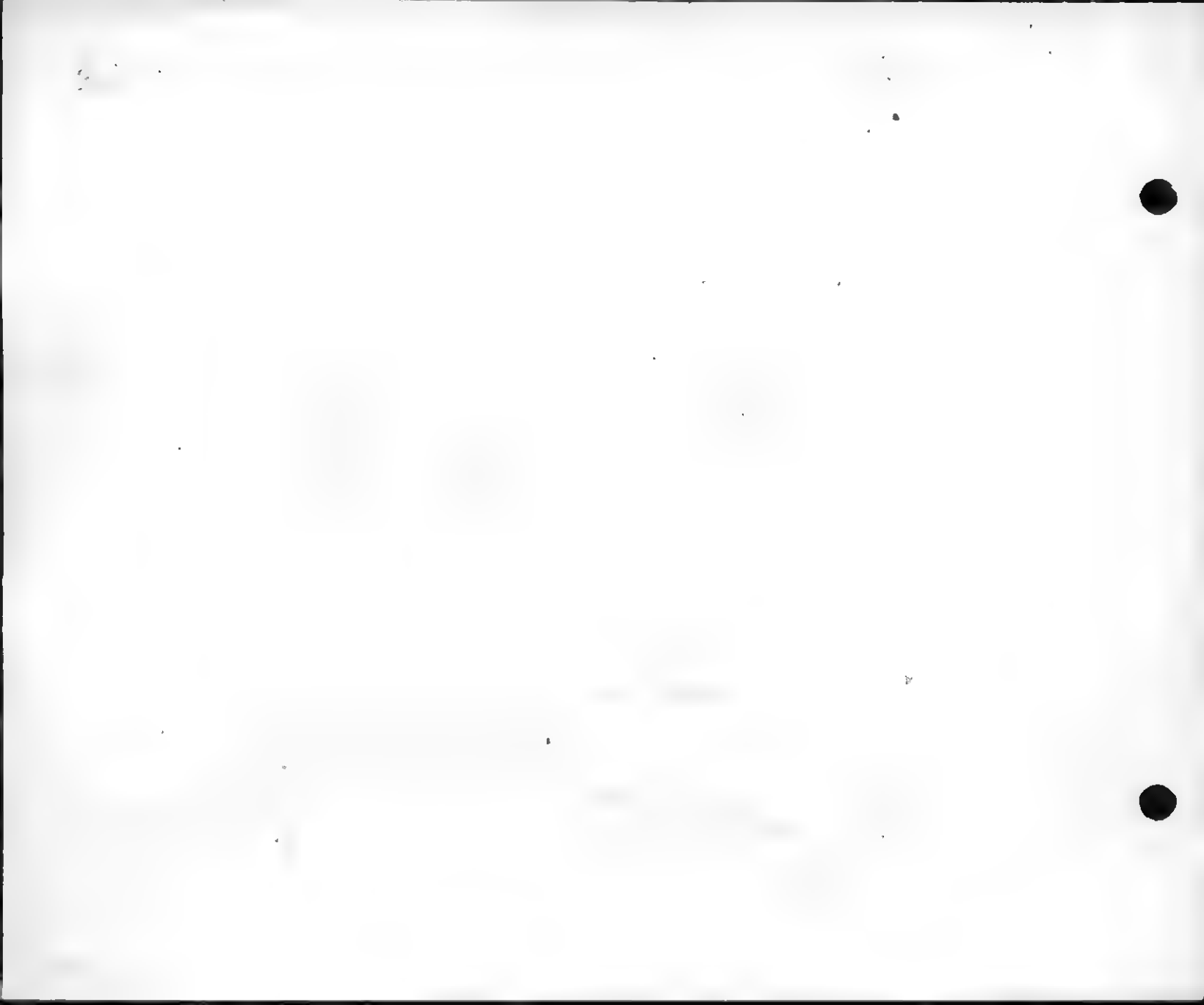
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15736

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Harford</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>N.Y.</u> b COUNTY <u>KINGS</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Harford</u>		c LENGTH OF STAY (If not in hospital, give street address) <u>70 min</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e STREET ADDRESS <u>1888 Haring St</u>	
3 NAME OF DECEASED (Type or print) <u>Katherine</u> First <u>Stratis</u> Middle <u>Stratis</u> Last		4 DATE OF DEATH <u>November 11</u> 19 <u>66</u> Month Day Year	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>FEB 3 1918</u> 9 AGE (In years, last birthday) <u>48</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11 BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>STEVE STRATIS</u>	
14 MOTHER'S MAIDEN NAME <u>ATHANASIA HOWES</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>UNK</u>	
16 SOC. A. SECURITY NO. <u>UNK</u>		17 INFORMANT <u>DAUGHTER</u> Address <u>Mrs. MERSINE MERCER, WOODBRIDGE, Va.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Frd + tuss + Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>16+</u> DUE TO (c) <u>16+</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Autoaccident, auto-auto-type</u>	
20c TIME OF INJURY Month, Day, Year <u>Nov 11 1966</u>	20d INJURY OCCURRED While <input type="checkbox"/> or at work <input type="checkbox"/> Not While <input type="checkbox"/> or at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Jer Highway</u>	20f (City or town) (County) (State) <u>Perryville Cecil Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		Address (Street, city, town, or county) <u>11-12-66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b DATE THEREOF <u>11/15/1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>CYPRESS</u>	23d LOCATION (City or Town) (County) (State) <u>BROOKLYN NY</u>
24 FUNERAL DIRECTOR <u>Ernest S. Harrell</u>		25a REC'D BY REG STRAR DATE <u>NOV 15 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15733

## CERTIFICATE OF DEATH

15735

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haverd Grace</u>		c. LENGTH OF STAY in 1b <u>1 hr 15 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>	
d. STREET ADDRESS <u>315 Roberts Way</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eugene</u> Middle <u>Gray</u> Last <u>Stout</u>		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Feb 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tech. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Stout</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Duff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>223-24-1233</u>	
17. INFORMANT <u>Peggy Stout, Aberdeen, Maryland</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>65</u> , to <u>Nov 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 30</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>B. J. Plunkett Jr.</u>		22b. DATE SIGNED <u>11-30-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>		22d. ADDRESS <u>Aberdeen, Maryland 21001</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>5 Dec 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Yonon Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Wilton Winculm Sr.</u>		25a. REC'D BY REGISTRAR <u>DEC 2 1966</u>	
Tarring Funeral Home Aberdeen, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1539

5552

1890

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15734

CERTIFICATE OF DEATH

15737

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>			c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> <u>1211</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>R D # 2 Box 165</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>AMANDA</u> First <u>MARGARET</u> Middle <u>ZIEHNERT</u> Last				4. DATE OF DEATH <u>November 10</u> 19 <u>66</u> Month Day Year				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>14 Mar. 1884</u>		
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Smithton, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK Yung</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE Allhouse</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Julian F. Ziehnert Bel Air, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exploratory lap - cholecystectomy &amp; lysis of adhesions</u> (c) <u>Spontaneous</u>							INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/26</u> , 19 <u>66</u> , to <u>11/10</u> , 19 <u>66</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>11/10</u> 19 <u>66</u> , and that death occurred at <u>9:54 A.M.</u> from causes and on the date stated above.								
22a. SIGNATURE <u>Charles J. Foley Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/10/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Charles J. Foley Jr. M.D.</u>				22d. ADDRESS <u>Havre de Grace, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial</u>		23d. LOCATION (City or town) (County) (State) <u>Bel Air, Maryland</u>		
24. FUNERAL DIRECTOR <u>John S. Tarring</u> Address <u>Aberdeen, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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